



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Delaware**

**Application for 2012
Annual Report for 2010**



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Table of Contents

I. General Requirements	5
A. Letter of Transmittal.....	5
B. Face Sheet	5
C. Assurances and Certifications.....	5
D. Table of Contents	5
E. Public Input.....	5
II. Needs Assessment.....	7
C. Needs Assessment Summary	7
III. State Overview	10
A. Overview.....	10
B. Agency Capacity.....	22
C. Organizational Structure.....	30
D. Other MCH Capacity	31
E. State Agency Coordination.....	34
F. Health Systems Capacity Indicators	39
Health Systems Capacity Indicator 01:	40
Health Systems Capacity Indicator 02:	41
Health Systems Capacity Indicator 03:	42
Health Systems Capacity Indicator 04:	43
Health Systems Capacity Indicator 07A:.....	43
Health Systems Capacity Indicator 07B:.....	44
Health Systems Capacity Indicator 08:	45
Health Systems Capacity Indicator 05A:.....	45
Health Systems Capacity Indicator 05B:.....	46
Health Systems Capacity Indicator 05C:.....	47
Health Systems Capacity Indicator 05D:.....	47
Health Systems Capacity Indicator 06A:.....	47
Health Systems Capacity Indicator 06B:.....	48
Health Systems Capacity Indicator 06C:.....	48
Health Systems Capacity Indicator 09A:.....	49
Health Systems Capacity Indicator 09B:.....	50
IV. Priorities, Performance and Program Activities	52
A. Background and Overview	52
B. State Priorities	53
C. National Performance Measures.....	56
Performance Measure 01:.....	56
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	58
Performance Measure 02:.....	58
Performance Measure 03:.....	60
Performance Measure 04:.....	63
Performance Measure 05:.....	65
Performance Measure 06:.....	67
Performance Measure 07:.....	70
Performance Measure 08:.....	72
Performance Measure 09:.....	74
Performance Measure 10:.....	76
Performance Measure 11:.....	78
Performance Measure 12:.....	80
Performance Measure 13:.....	83
Performance Measure 14:.....	84
Performance Measure 15:.....	86
Performance Measure 16:.....	88

Performance Measure 17:.....	89
Performance Measure 18:.....	91
D. State Performance Measures.....	93
State Performance Measure 1:	93
State Performance Measure 2:	95
State Performance Measure 3:	96
State Performance Measure 4:	98
State Performance Measure 5:	100
State Performance Measure 6:	102
State Performance Measure 7:	104
State Performance Measure 8:	106
State Performance Measure 9:	108
State Performance Measure 10:	110
E. Health Status Indicators	112
Health Status Indicators 01A:.....	112
Health Status Indicators 01B:.....	113
Health Status Indicators 02A:.....	113
Health Status Indicators 02B:.....	114
Health Status Indicators 03A:.....	115
Health Status Indicators 03B:.....	116
Health Status Indicators 03C:.....	117
Health Status Indicators 04A:.....	118
Health Status Indicators 04B:.....	120
Health Status Indicators 04C:.....	121
Health Status Indicators 05A:.....	122
Health Status Indicators 05B:.....	124
Health Status Indicators 06A:.....	125
Health Status Indicators 06B:.....	125
Health Status Indicators 07A:.....	126
Health Status Indicators 07B:.....	126
Health Status Indicators 08A:.....	127
Health Status Indicators 08B:.....	127
Health Status Indicators 09A:.....	128
Health Status Indicators 09B:.....	129
Health Status Indicators 10:	130
Health Status Indicators 11:	130
Health Status Indicators 12:	130
F. Other Program Activities.....	131
G. Technical Assistance	132
V. Budget Narrative	134
Form 3, State MCH Funding Profile	134
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	134
Form 5, State Title V Program Budget and Expenditures by Types of Services (II).....	135
A. Expenditures.....	135
B. Budget	136
VI. Reporting Forms-General Information	141
VII. Performance and Outcome Measure Detail Sheets	141
VIII. Glossary	141
IX. Technical Note	141
X. Appendices and State Supporting documents.....	141
A. Needs Assessment.....	141
B. All Reporting Forms.....	141
C. Organizational Charts and All Other State Supporting Documents	141
D. Annual Report Data	141

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certification Forms are kept on file in the State MCH program's office and can be made available by request to Alisa Olshefsky, M.P.H, Director of Maternal and Child Health or Leah Jones, MCH Deputy Director. The State MCH Program Office is located at 417 Federal Street, Jesse Cooper Building, Dover, DE 19901 (The State Public Health Administration Building).

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The MCH Bureau initiated a series of intimate in-person "listening sessions" or "coffee klatches" all across Delaware in early April 2010 targeting families of CYSHCN. Sessions lasting 1.5 hours were set for seven sites across all three Delaware counties at well known and easily accessible State Service Centers. A Spanish language interpreter was available. Sign language interpretation was available on request. Both English and Spanish language flyers were disseminated across various partner and contractor email lists and listservs and websites. Turnout was not as high as hoped. However this was the first year of the strategy, the MCH program is confident that this strategy should be institutionalized and become a part of regular outreach to families of CYSHCN.

In April 2010, the Family Support Initiative (FSI), in partnership with MCH, held a partner meeting with CYSHCN-serving organizations and parent-led groups. During the meeting, the Title V needs assessment was discussed and participants were asked to share an executive summary and brief survey with all the parents and families they represent or connect with on a daily basis. Families could select to provide survey feedback via email, web survey, or hard copy through a self-address stamped envelope. Families were asked to respond to three core questions in addition to free form comments:

- If you could give advice to service providers about how they can improve family/individual involvement in decision-making, what would you say?
- Do you feel that our performance measures are on track as it relates to those who support families with special health care needs?
- Is there anything else you would like to tell us that would help us understand how families of children with special health care needs can be served better in Delaware?

Family feedback was incorporated into the final version of the state priorities around CYSHCN. The support of community organizations involved in FSI was essential to wide spread dissemination of the survey. They endorsed the process and shared the information with families they serve.

In May 2010, the MCH program presented to the Delaware Healthy Mother & Infant Consortium regarding the needs assessment. Similar to the CYSHCN forum, DHMIC members were provided an executive summary and asked to complete three questions about the proposed state priorities. The DHMIC was an ideal forum for feedback since the coalition is composed of over eighty organizations serving women, families, infants and youth. Feedback was provided via email and web-based survey.

In the web-based survey, parents were asked what advice they would give to providers and whether the performance measures for CSHCN were "on track." Parents (n=5) responded that providers should make more information available to families, ask families directly for their feedback, respect the input of families and eliminate bureaucratic barriers in the referral process. Parents thought that generally, the performance measures were on track in measuring their concerns, however there was some sentiment that the performance measures were vague in terms of measuring effectiveness.

//2012/ In 2011, the MCH Title V Director and Deputy Director have made a concerted effort to introduce and incorporate the ten MCH priorities into stakeholder meeting discussions and strategic activities, identified through Delaware's five year needs assessment. Delaware provided the following opportunities for public input:

- ***Public Health Web Posting***
- ***Outreach to stakeholders (Delaware Healthy Mother Infant Consortium, Family SHADE, Family to Family Health Information Center, councils and consortia)***

Planning is under way for 2012 to develop new "Meet and Greet" forums (i.e. listening sessions, coffee klatches), similar to what was initiated in April 2010, whereby the MCH Deputy Director will develop a brief road show power point presentation and share all of the current project initiatives that address the top ten MCH Priorities, identified in the Needs Assessment, with stakeholders and families. The Meet and Greet forums will also serve as an opportunity to share knowledge and expertise, build collaborative partnerships, and encourages an open and ongoing dialogue to address MCH priorities. //2012//

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Delaware Maternal and Child Health (MCH) program began working on the Five Year Needs Assessment early in 2008. The intent was to review, assess, and re-vamp the MCH Block Grant-related activities and programs to ensure the state performance measures were not duplicative of national measures and that they truly reflected state priorities. Moreover, it was determined that the 2010 Needs Assessment should serve as a living document to guide and serve as a metric for MCH programs and services. In summer 2008, an internal workgroup was established and trained on the Capacity Assessment for State Title V process (CAST-5). In September 2008, the MCH Needs Assessment Workgroup was formally established (SECTION II). This workgroup included the internal Division of Public Health (DPH) workgroup along with families, advocates, clinicians, and organizations serving children and youth with special health care needs (CYSHCN). A total of 35 individuals from across the State of Delaware participated in the needs assessment process.

After the workgroup was formed, tools and strategies were used to help identify state priorities. Over the course of seven months, the MCH Needs Assessment Workgroup established criteria, including weighting and ranking parameters for 33 varied health conditions affecting the MCH population groups. By using a dual approach of individual and group ranking of health conditions, workgroup members could be engaged on each condition while still focusing on those that most impacted/interested them. The capacity of Delaware's current MCH-related programs to meet the needs of persons affected by these health conditions was also determined using the MCH Pyramid of Health Services conceptual framework.

Ten state health priorities emerged from the MCH Needs Assessment process. Delaware's 2010 MCH priorities include:

1. Infant Mortality. Decrease infant mortality and eliminate the disparity in infant mortality among Black women.
2. Low Birth Weight/Preterm Births. Decrease low birth weight (= 2500 g) and very low birth weight (= 1500 g) births and births occurring between 32 and 36 weeks gestation.
3. Obesity and Overweight Among Children & Teens. Decrease obesity and overweight among children and youth between the ages of 6 and 19.
4. Obesity Among Women of Childbearing Age. Decrease obesity among women of childbearing age - between the ages of 15 and 44.
5. Unintentional Injury Among Infants, Children & Teens. Decrease unintentional injuries and deaths due to unintentional injuries among children and youth between birth and age 21.
6. Teen Smoking. Decrease tobacco use among adolescents.
7. Family Support for Children and Youth with Special Health Care Needs. Increase effectiveness and efficiency of organizations that serve families of children with special health care needs.
8. Developmental Delay. Increase the percentage of children who are either at low- or no- risk of developmental, behavioral or social delays.
9. Disparities Among Families of Children and Youth with Special Health Care Needs. Decrease disparities in child health, emotional/mental health, health care access/quality and family health indicators among children and youth with special health care needs.
10. Child Oral Health. Decrease the percentage of children with untreated caries and eliminate the disparity in untreated caries among Black children.

The Delaware 2010 Needs Assessment represents the first step in a cycle of continuous improvement of maternal, child, and adolescent health. Between 2010 and 2015, actions and strategies will be implemented, results will be monitored and evaluated under the State Performance Measures included in this application, and supplementary data, and necessary adjustments will be made in an effort to enhance the health of women, children, and adolescents in Delaware.

The complete 2011-2015 Needs Assessment Report is attached.

/2012/The last year has truly been a long and exciting journey for Delaware's Maternal and Child Health Bureau. With the celebration of the 75th Anniversary of MCH, it was an opportune time to grow and build the leadership skills of our MCH personnel as well as our partners. In addition, it was a time to be reflective and celebrate all that has evolved and emerged to improve the health and well-being of women, infants, children and children with special health care needs and the challenges that we still need to address. The introduction of the Life Course framework has helped Delaware think through integrated approaches that are efficient systems of care, share similar goals, and require collaborative partnerships across sectors and agencies, which produce optimal outcomes for women, children and youth and their families across the lifespan.

Delaware is using a science-based model, the life course approach, to address women's health across the lifespan, weaving together behavioral, biological, environmental, psychological, and social factors that contribute to health outcomes. Delaware is focusing its efforts on the health of the mother from the day she enters this world to birth of her child. Through the collaborative Delaware Healthy Mother Infant Consortium, several programs have been implemented for the woman herself, her family, her health care provider and her community. The State of Delaware 2010 MCH Needs Assessment [Maternal and Child Health Title V Five Year Needs Assessment] points to several poor birth outcome indicators listed within the top ten maternal and child health state priorities. These indicators and their respective state priority goals include:

- 1. Infant Mortality: Reduce infant mortality and eliminate the disparity in infant mortality for Black women;***
 - 2. Low Birth Weight: Reduce low birth weight (less than 2500 grams) and very low birth weight (less than 1500 grams) deliveries;***
 - 3. Preterm Births: Reduce births occurring between 32 and 36 weeks gestation.***
- In addition to these three indicators, poor preconception and prenatal health are associated with another top state priority, Obesity Among Women of Childbearing Age.***

A network of diverse stakeholders have poured time, energy, and resources into a well-researched and designed prenatal and preconception initiative to improve women's health, birth outcomes and reduce infant mortality:

Provide health care, mental health and nutrition services for women before, during and after pregnancy through the Healthy Women Healthy Babies Program. During fiscal year 2010, six out sites have entered data statewide serving 5,866 women across the state.

- Develop two reproductive health education tools, one for adults and one for teens, which aims to reach more than 100,000 in the first year. These toolkits are designed to help teens (youth between 15 and 18) and women identify their goals in life and write down specific steps for developing healthy relationships and healthy lifestyles. Using social media, the teen life plan is available at www.facebook.com/MyLifeMyPlan. A male reproductive health plan is under development.***
- Provide genetic counseling for those at risk of having an infant born with a birth defect.***
- Continue Kicks Count, a successful statewide awareness campaign dedicated to improving the chances of delivering a healthy baby by reducing stillbirth rates, which occur in one out of every 150 pregnancies nationwide. A tool kit has been designed to educate expectant parents about the importance of kick counting in monitoring a baby's***

health beginning at 24 weeks. This tool kit contains materials that will help expectant parents learn to track kick counts.

- *2011 Annual Maternal and Child Health conference, Enhancing the Future of Delaware reaches over 200 Delawareans*
- *Better serve our diverse population, by providing Spanish-language interpretation services for more than 500 patients per year.*
- *Immunizations and folic acid supplements, as well as health screenings for stress, intimate partner violence, exposure to toxins and drug/alcohol use are standard under the program.*
- *Through the prematurity prevention program, provide progesterone to women at risk of having a premature baby. Over the past year, the program helped 30 mothers who delivered at Christiana Care avoid premature labor and delivery.*
- *Continue to collect and analyze data on the health of pregnant women, fetal deaths, infant deaths and birth defects. We now have a better understanding than ever about why Delaware's infant mortality rate is so high.*
- *We expect these programs to show results in prematurity, low birth weight and infant mortality over time. The infant mortality rate in Delaware dropped 10% from its peak of 9.3/1,000 births (2000--2004) to 8.4/1,000 births (2004--2008). Although there has been a long-term trend of increasing low birth weight babies, Delaware has had no increase since 2001. Preliminary 2008 Vital Statistics data indicate that Delaware had the 16th highest percentage of low birth weight births (births less than 2,500 grams) in the nation at 8.5%. Delaware had the 16th highest preterm birth rate (less than 37 weeks of completed gestation) in the nation at 12.9% according to preliminary 2008 data.*

Delaware also worked tirelessly over the last year focused on state priority #7. The Family Support Initiative (FSI), an alliance of 40+ organizations and agencies, is committed to working together to improve the quality of life of children and youth with special health care needs (CYSHCN) by improving access to information and services in Delaware. Partner organizations and families of CYSHCN provide input and strategic guidance to FSI's work via their participation on its Advisory Council. With support by Title V, the Center for Disabilities staff that are devoted to FSI, shepherded the launch of the umbrella activities very carefully to ensure that our collaborators felt a genuine sense of ownership and self-determination in governance, direction, and implementation.//2012// An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Title V Agency Overview

The Delaware Department of Health and Social Services (DHSS) consists of 12 distinct divisions and the Delaware Health Care Commission with an overarching mission to improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. The Delaware Division of Public Health (DPH), the largest division within DHSS, is the Title V agency responsible for planning, program development, administration and evaluation of maternal and child health (MCH) programs statewide. DPH is led by Karyl Rattay, MD, MS, FAAP, FACPM who serves as the Division Director. Within DPH, the Family Health and Systems Management (FHSM) section has direct oversight of Title V, as well as a number of other MCH programs including the Children with Special Health Care Needs (CSHCN), the Early Childhood Comprehensive Systems (ECCS) Program, the Newborn Metabolic Screening Program, the Newborn Hearing Screening Program, the Birth Defects Registry, the Autism Registry, the State Systems Development Initiative, the Adolescent Health Program, the Infant Mortality Elimination Program, the Center for Family Health Research and Epidemiology, the Title X Family Planning Program and the Health Systems Management Bureau (including program management of rural health, Federally Qualified Health Centers [FQHCs], and the Conrad State 30/J-1 Visa Program -a recruitment program for physicians).

FHSM is managed by a Section Chief, Alisa Olshefsky, MPH, who also serves as the state's Maternal and Child Health Director. FHSM is structured into four Bureaus: The Maternal & Child Health Bureau (which directly administers Title V), the Adolescent & Reproductive Health Bureau, the Center for Family Health Research and Epidemiology and the Bureau of Health Resources Management.

//2012/In addition to programmatic efforts under FHSM, the Title V MCH Block Grant Program funds staff positions in community public health clinics for three key programs. These programs are Smart Start, Child Development Watch (CDW), and the State's Oral Health Program. Field staff is under the direction of the State's Medical Director, Herman Ellis, M.D. Smart Start is a prenatal program addressing women at-risk for poor birth outcomes and focuses on child health for children through 3 years of age. Over the last year, Public Health's home visiting program, Smart Start, went through a rigorous planning process to transition to a comprehensive "evidence-based" home visiting program under the Healthy Families America model. As part of a comparative analysis led by the Delaware Maternal & Child Health Bureau during 2010, an assessment was completed of DPH home visiting services. The MCH program provided leadership on a project to assess the applicability of evidence-based home visitation. In collaboration with other community-based MCH organizations, the state is integrating a comprehensive home visiting program where families are referred to different programs through a centralized intake (e.g. Nurse-Home Visiting, Healthy Families America and Parents as Teachers) depending on needs and eligibility. CDW is a program dedicated to screening, case management and referral for CSHCN from birth through 3 years of age and their families. The Oral Health Program provides preventive dental services to children. In addition to Title V funds, state general funds and appropriated special funds (fees, revenue, for example) also support staff in these programs. //2012//

Each of the programs within FHSM is integrated with a common mission and strategic objectives. The mission of the FHSM section is to improve the health of families and provide leadership to communities in the development of health systems. FHSM accomplishes its mission by:

- developing, coordinating and evaluating programs and initiatives to improve the health of women, infants, children, adolescents and those with special health care needs;

- monitoring health status through newborn screening (metabolic disorders and hearing), birth defects and autism registries;
 - eliminating disparities in maternal and child health outcomes, including infant mortality;
 - ensuring access to adolescent health care services through School-Based Health Centers (SBHCs) and implementing programs to reduce teen pregnancy;
 - applying epidemiology and research to improve delivery of quality health care to women, children and families;
 - enhancing reproductive health and ensuring access to family planning services;
 - translating evidence into practice to improve early childhood comprehensive systems of care; and
 - ensuring health systems across the state have the ability to meet Delawareans' health care needs by focusing on primary care, rural health, identifying and addressing health care provider shortages, and helping to improve access to data and health information. FHSM's programs address the following areas.
- The Children with Special Health Care Needs program works closely with Child Development Watch, the state's birth to three program, and other organizations throughout the State to coordinate services and address key issues including transition to adult services, family involvement and capacity building. In the past year, a major addition to the CSHCN program has been the implementation of a Family Support Initiative, through the University of Delaware's Center for Disabilities Studies, to provide coordination and other support among the state's assorted organizations and groups that serve families with Children with Special Health Care Needs.
 - The ECCS Program partners with organizations throughout the state to plan, to develop and to implement partnerships to support child development and ensure that all Delaware's children are healthy and are ready to learn at school entry. ECCS is instrumental to the planning and development of the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program.
 - The Newborn Metabolic Screening Program and Newborn Hearing Screening Program screen newborns for metabolic conditions and hearing deficiencies, as well as maintain the state's Birth Defects and Autism registries.
 - The State Systems Development Initiative works with Title V in building capacity for data analysis and the linking of MCH datasets. SSDI also is a key participant in the development of an early childhood data system under the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program, as well as the MCH needs assessment process. SSDI also works closely with the Center for Family Health Research and Epidemiology on pilot studies.
 - The Infant Mortality Elimination Program funds contractual programs for at-risk pregnant women and preconception programs for women (Healthy Women, Healthy Babies. The Infant Mortality Elimination Program's initiatives also include a research component (including the Pregnancy Risk Assessment Monitoring Surveillance survey) carried out through the Center for Family Health Research and Epidemiology and the State's Fetal Infant Mortality Review (FIMR) Program (through the Administrative Office of the Courts).
 - Title X, the federal Family Planning Program, works closely with Title V on a wide range of issues including teen pregnancy prevention, preconception care and women's health issues.

- School-Based Wellness Centers are located in high schools statewide and provide preventive services to students.
- Teen Pregnancy Prevention programs (Wise Guys and Making Proud Choices) are offered throughout the state to reduce the risks of STDs and the incidence of teen pregnancy.

Title V related activities throughout FHSM and DPH support the stated section mission across each of the four levels of the MCH pyramid (direct services, enabling services, population-based services and infrastructure building activities) as detailed further throughout this application. The next section broadly describes the current system contexts, including some of the principal characteristics of the state's maternal and child health populations. Population Characteristics

Population Characteristics

Delaware is a small mid-Atlantic state located on the eastern seaboard of the United States. Geographically, the state's area encompasses only 1,983 square miles ranking Delaware 49th in size among all states. Delaware is bordered by the states of New Jersey, Pennsylvania and Maryland, as well as the Delaware River, Delaware Bay and Atlantic Ocean. Centrally located between four major cities, Wilmington, the state's largest urban center is within an hour's drive to Baltimore, MD and Philadelphia, PA and within two hours driving distance from New York City and Washington, D.C.

According to the latest population estimates, in 2010 the State of Delaware had about 896,880 residents, of which 75% were Caucasian and 21% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Of Delaware's three counties, New Castle County, in the northern third of the state, is the largest in population with about 539,590 residents or about 60% of the state's total population. New Castle County also has a large population of African-American residents (about 24%) and within the city of Wilmington, the state's largest concentration of African-American residents (about 55 percent of the city's population). New Castle County also has the largest proportion of Hispanics. Kent County and Sussex County, located in the southern two-thirds of the state, are more rural than New Castle County. In 2010, the estimated population of Kent County was about 159,980 residents (75% Caucasian and 23% African-American). For Sussex County, which includes very rural areas as well as coastal resort towns, the 2010 population was about 197,310 (85% Caucasian). Since 2000, the State's population has increased by about 14.0 percent.

In 2010, statewide, it is estimated that there are about 172,250 women of childbearing age (15-44 years of age) and 253,000 infants, children and adolescents aged 0-21 years of age. Annually in the state, about 13,000 infants are born.

Economic Indicators

In Delaware, from 2008-2010, it is estimated that 15.2% of children, aged 0-17, were living in poverty, with the highest rates among those children aged 0-5 (17%). Children in Kent and Sussex County are slightly more likely to live in poverty than children in New Castle County (17.8% vs. 13.8%). During the same time period, 19.6% of Delaware's children lived in a household with underemployed parents (where no parent worked full-time, year round). Over one-quarter (28.3%) of children from single parent households in Delaware lived in poverty compared to 6.8% of children living in two parent households. The median income of two parent households in Delaware from 2008-2010 was \$85,393 compared to \$28,599 for single parent

households and \$26,202 for female-headed households. Of Delaware's children, 35.6% lived in a one-parent household in the 2008-2010 time period. Almost half (45.4%) of births occurring in the five year period 2004-2008 were to single mothers with 71.5% of African American births occurring among single mothers compared to 37.7% of Caucasian births occurring among single mothers (Kids Count in Delaware, 2011). It is estimated that 13.5% of Delawareans below the age of 65 are without health insurance. As of August 2010, 68,738 adults and 60,849 children received food assistance through Delaware's Supplemental Nutrition Assistance Program (SNAP) and 2,632 adults and 9,271 children received cash assistance through the Temporary Assistance to Needy Families Program (TANF) (KIDS Count in Delaware, 2011).

As with much of the nation, the current overall economy in Delaware is the worst since the mid-1970's. As of April 2011, Delaware's seasonally adjusted unemployment rate was 8.2% (compared to 9% nationally) (Delaware Department of Labor, May, 2011). This is the lowest in Delaware since August 2009, when the unemployment rate was on the rise to a peak of more than 10 percent. Over recent years, the greatest job losses have occurred in federal government, wholesale trade, transportation, and utilities (Delaware Department of Labor, May, 2011). Currently, Delaware's largest employment sector is Trade, Transportation and Utilities (18% of the non-farm workforce), followed closely by education and health (16%), and government (15%) (Delaware Department of Labor, May, 2011).

Geographic Health Disparities

Although the state is relatively small, disparities exist between the state's three counties as well as between rural and urban areas of the state with regard to healthcare access and utilization.

Delaware, like other states, faces a shortage of health professionals. Specifically, Kent County, Sussex County, and parts of the City of Wilmington have been federally designated as health professional shortage areas. There are particular shortages among primary care physicians, dentists, nurses and mental health professionals. Ultimately, these shortages threaten the ability of health care entities in Delaware to provide timely access to quality care.

//2012/ At the request of the State Office of Primary Care and Rural Health, the federal government designated the Middletown and Odessa area and the Claymont and Edgemoor area as Governor's Medically Underserved Population (MUP) areas. The designation qualifies existing or new healthcare entities within those areas to qualify for state and federal resources, including federal funding through the Federally Qualified Health Center program. Westside Family Health is interested in expanding services to underserved areas.

Mental Health Professionals in Delaware 2009 report, published by the Division of Public Health in collaboration with the University of Delaware's Center for Research and Applied Demography, assesses the supply and distribution of mental health professionals, including psychiatrists and mental health specialists. It will be used to assess if federally-designated mental health shortage areas meet minimum requirements and if new areas qualify. Within four years, Delaware lost 43 full-time equivalent (FTE) mental health professionals due to payment and insurance challenges. In 2005, there were 534 mental health professionals (stateside ratio of each FTE mental health specialist was 1:2,000 persons and each FTE psychiatrist was 1:7,075 persons). However, by 2009, there were 491 FTE mental health professionals (stateside ratio of each FTE mental health specialist was 1:2,209 persons and each FTE psychiatrist was 1:9,582 persons). //2012//

Statewide, the percentage of women accessing prenatal care in the first trimester was higher than the national average for the five year period 20012002-2005 2006 (87.482% for Delaware vs. 72.766.7% for the United States). In the most recent available two five year periods (20022003-2006 2007 and 20032004-20072008) however, the statewide percent of women accessing prenatal care in the first trimester has been declining (8278% and 7873.9%, respectively). This

decline has been reported in each of the state's three counties, as well as the city of Wilmington. In the 2003-2004-2007-2008 reporting period, Sussex County was lowest in terms of pregnant women accessing prenatal care in early pregnancy (63.59.3.4% vs. 71.568.9% for Kent County. 84.580.2% for New Castle County and 77.973.4% for the City of Wilmington). It is important to note that these data were reported prior to full scale operation of the State's current Infant Mortality indicators (Healthy Women, Health Babies).

//2012/ According to the National Vital Statistics System (2009), the rate of preterm births in Delaware has been consistently higher than of the nationwide rate and in 2007, Delaware ranked 8th in the nation for babies born low birth weight. Prematurity and low birthweight were the leading sources of infant mortality in Delaware, causing 24 percent of infant deaths in Delaware in the 2004-2008 period. Given these figures, the need to reduce preterm births is of the utmost importance to the state. Reducing preterm births is a priority need established by Delaware's 2010 MCH Needs Assessment. //2012//

From 2004-2008, in terms of birth outcomes, Wilmington is the geographic area with the highest percentages of low birth weights (13.4% compared to 9.1% statewide) and very low birth weights (2.8% compared to 1.9% statewide).

From 2004-2008, New Castle County had a higher infant mortality rate than the state as a whole (9 infant deaths per 1,000 live births compared to 8.4 infant deaths per 1,000 statewide). However, the driving force in New Castle County infant mortality is within the City of Wilmington (13 infant deaths per 1,000 compared to 9 infant deaths per 1,000 in the balance of the county).

The City of Wilmington and Sussex County have the highest teen birth rates (86.0 and 60.3 births per 1,000 females aged 15-19) over the five year period 2004-2008. Statewide, the teen birth rate during this period was 43.1 (compared to 41.6 births per 1,000 females nationally). In the state in general, the teen birth rate among black teens exceeds the teen birth rate among white teens (66.4 vs. 35.2 births per 1,000 females aged 15-19). In the City of Wilmington, however, the teen birth rates are comparable among both black and white teens (91.1 vs. 92.5 live births per 1,000 females aged 15-19, respectively).

Among 11th grade students, Sussex County has the highest rates of youth tobacco (18% compared to 14% statewide). Kent County has the highest rates of alcohol (39% compared to 37% statewide). New Castle County has the highest rates of substance use (25% compared to 24% statewide).

The City of Wilmington, similar to many urban areas throughout the nation, has correspondingly high rates of social risks and poor health outcomes such as juvenile arrests, high school drop-outs, HIV/AIDS (with a high proportion attributable to needle sharing) and sexually transmitted infections.

According to the 2000 U.S. Census, Kent County is the county with the highest risk of poverty ratio (2.5, comparing female headed households to male householder families). However, both Kent and Sussex Counties exceed the statewide percent of female headed household families living in poverty (30.2% and 31.1%, respectively, compared to 26.3% statewide).

The City of Wilmington, similar to many urban areas throughout the nation, has correspondingly high rates of social risks and poor health outcomes such as juvenile arrests, high school drop-outs, HIV/AIDS (with a high proportion attributable to needle sharing) and sexually transmitted infections.

Racial/Ethnic Disparities

In 2008, the Office of Minority Health released the Delaware Racial and Ethnic Disparities Health Status Report Card. This report highlighted many problematic indicators of health disparities between African-Americans, Hispanics and Caucasians (the reference group) using a "disparity

ratio" as the indicator. The African-American Infant Mortality rate from 2001-2005 was found to be 2.5 times that of Caucasians (17.1 vs. 6.8 per 1,000 live births). For the same time period, the percent of Hispanics with late or no prenatal care was 2.7 times that of Caucasians (9.1 vs. 3.4). The rate of diabetes among African Americans in Delaware from 2001-2005 was 2.2 times that of Caucasians (49.2 vs. 22.5 per 100,000 population). For the same time period the adjusted HIV mortality rate among African Americans was 14.5 times that of Caucasians. The report also noted that among Hispanics, the birth rate to teenage mothers was 3.8 times higher than Caucasians from 2001-2005 (131.4 vs. 34.4 per 1,000 females, age 15-19).

Children and Youth with Special Health Care Needs (CYSHCN)

/2012/Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills. In 2007, 19% of children nationwide under age 18 years were classified as having special health care needs (i.e., children with an increased risk of chronic physical, developmental, behavioral, or emotional conditions and who also required health and related services of a type or amount beyond that required by children generally). In 2007, 24% of children under age 18 years in Delaware were classified in this manner; this places Delaware (along with Alabama, Arkansas, Kentucky, and Louisiana) as the states with the highest percentage of children with special health care needs.1 This is an increase from 15% in 2001 and 17% in 2005-2006.5 //2012//

In 2010, 870 children ages 0-3 years received early intervention services in accordance with Part C in Delaware. Of these children, 49.31% were White non-Hispanic, 25% were Black non-Hispanic, 9.8% were Hispanic, 2.6% were Asian or Pacific Islander, and 0.34% were American Indian or Alaska Native. Children ages 2-3 years accounted for 59.66% of the children receiving services while 28% were ages 1-2 years and 12.3% were birth to 1 year of age. Finally, 61.6% of the children receiving services were male and 38% were female.

Based on rates from the 2005-2006 National Survey of Children with Special Health Care Needs, of families of children to age 18, it is estimated that about 34,500 Delaware children (17.5%) younger than age 18 years may have a special health care need. Around 7,000 (20.4%) of Delaware's CSHCN have health conditions that consistently and often greatly affect their daily activities. Rates were somewhat higher for Black children (22.5%) compared to 17.9% for Caucasian children. Rates were also far higher for families with incomes less than 100% of the federal poverty level (FPL) (32%) and for those between 100% and 200%, (30.5%) compared to 12%-18% for other income groups. As seen in the table below, Delaware had higher prevalence of CSHCN, a greater percentage of households that have at least one child with special healthcare needs; and a higher rate of CSHCN in every age and racial category and gender, than the national average.

Table 1: Select Delaware Data from the National Survey of Children with Special Health Care Needs, 2005/2006

Prevalence Statistics

	State %	Nation %
Percentage of Children & Youth with Special Health Care Needs, 0 - 17 yrs old	17.5	13.9
Prevalence by Age:		
Children 0-5 years of age	10.4	8.8
Children 6-11 years of age	21.8	16.0
Children 12-17 years of age	20.5	16.8
Prevalence by Sex:		
Female		13.3

11.6		
Male	21.5	16.1
Prevalence by Poverty Level:		
0% - 99% FPL	17.6	14.0
100% - 199% FPL		16.5
14.0		
200% - 399% FPL		17.6
13.5		
400% FPL or greater	17.9	14.0
Prevalence by Race/Ethnicity:		
Hispanic		9.2
8.3		
White (non-Hispanic)	19.6	15.5
Black (non-Hispanic)	16.0	15.0
Multi-racial (non-Hispanic)		17.0 17.9
Asian (non-Hispanic)	6.3
Native American/Alaskan Native (non-Hispanic)	14.5
Native Hawaiian/Pacific Islander (non-Hispanic)	11.5

The National Survey of Children with Special Health Care Needs Survey data suggest that in 2005 about 4,900 (14.2%) of Delaware's CSHCN younger than age 18 years had one or more unmet needs for specific health care services. Rates were higher for Black (27.7%) and Hispanic children (33.2%), compared to 11.7% for Caucasian children. Close to half of children living in families less than 100% FPL had unmet needs, 19.4% for those 100% to 200%, and 12.7% 200% to 400%. Those families with private insurance were half as likely to report unmet needs (9.8%), compared to those with public insurance (17.9%). It is unclear from the data what the unmet needs of these populations are specifically.

The Survey data also indicate that 29.7% of all Delaware CSHCN are without family-centered care. More than 50% of Hispanic (53.8%) and 47.5% Black CSHCN are without family centered care, compared to 27.1% for Caucasian. About half of CSHCN living in families below 200% did not have family-centered care, compared to fewer than 30% at higher income levels. Family centered-care is a philosophy that incorporates the family as an integral component of the health care system. These data on unmet needs, lack of family-centered care, and lack of a medical home indicates the disparate needs of Black and Hispanic families and low-income families.

According to the 2005-2006 National Survey of Children with Special Health Care Needs, 57.6% of families with CSHCN do not receive the services necessary to make the appropriate transition to adult health care, work and independence. In 2007, the University of Delaware's Center for Disabilities Studies completed a survey project focusing on CSHCN transition to adult services. The survey focused on three main research questions: 1) Do young adults who leave pediatric medical care at A.I. duPont Hospital (Delaware's only children's hospital), have primary and specialized adult medical care to address they typical and specialized chronic health care needs? 2) To which types of adult health care services do young adults have access after they transition from A.I. duPont. 3) How satisfied are these young adults and their families with the care they receive in the community?

The survey found that while the majority of young adults report access to specialist care, many of these young adults did not have a specialist. Despite this perceived access, one-half of respondents did not have a specialist. Moreover, among those without a specialist, 39% reported they do not know the type of specialist they need. A large majority of the respondents was very satisfied with their adult primary care provider, but about half expressed encountering difficulty in the process of transitioning to adult services.

The findings of this study supports the NSCSHCN data that adult transitions are problematic for many youth. The process of transition was reported as difficult by about 50% of study participants. They also reported child health services much easier to navigate than adult health services. In addition, participants reported many services available in the child system were not available in the adult system (e.g., daily care support).

/2012/ Disparities Among Families of CYSCHN in Delaware

Based on findings from the 2007 National Survey of Children's Health (NSCH), a number of key disparities have been identified for CYSCHN when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators. According to the 2007 NSCH: Disparities in Child Health Indicators

General Health. Among those aged 0-17 years in Delaware, 71.0% of CYSCHN were reported to be in overall excellent or very good health. This compared to 88.7% of non-CYSCHN.8

Oral Health. Among those aged 1-17 years in Delaware, 64.1% of CYSCHN were reported to have teeth that were in excellent or very good condition. This compared to 75.2% of non-CYSCHN. In this same age range, although not statistically significant, 15.2% of CYSCHN were reported to have two or more oral health problems in the past six months. This compared to 8.1% of non-CYSCHN.8

Disparities in Emotional and Mental Health

Parental Concern. Among those aged 4 months to 5 years in Delaware, 58.0% of parents of CYSCHN reported concern over their child's physical, behavioral or social development. This compared to 36.4% of parents of non-CYSCHN.8

At-Risk Children. Among those aged 4 months to 5 years in Delaware, 28.5% of CYSCHN were reported to be at high risk for developmental, behavioral, or social delay. This compared to 7.2% of non-CYSCHN.8

Social Behaviors. Among those aged 6-17 years in Delaware, 81.1% of CYSCHN were reported to consistently exhibit positive social behaviors. This compared to 94.6% of non-CYSCHN. Furthermore, among this same age cohort, 24.8% of CYSCHN were reported to often exhibit problematic social behaviors. This compared to 4.5% of non-CYSCHN.8

Disparities in Health Care Access and Quality

Continuous and Coordinated Health Care. Among those aged 0-17 in Delaware, 48.4% of CYSCHN were reported to have a medical home that provided continuous, coordinated, comprehensive, family-centered and compassionate health care services. This compared to 63.6% of non-CYSCHN.8

Effective Care Coordination. Among children needing care coordination in the past year, 52.1% of CYSCHN were reported to receive effective care coordination. This compared to 79.3% of non-CYSCHN.8

Specialist Care. Among children that needed specialist care in the past year, 14.2% of CYSCHN were reported to have had problems getting specialist care. This compared to 3.9% of non-CYSCHN.8

Disparities in Family Health

Mother's Health. Among children in Delaware that lived with their mother, 53.9% of mothers of CYSHCN were reported to be in very good or excellent general health. This compared to 66.6% of mothers of non-CYSHCN.8

Mother's Mental/Emotional Health. Among children in Delaware that lived with their mother, 63.2% of mothers of CYSHCN were reported to have very good or excellent mental or emotional health. This compared to 75.4% of mothers of non-CYSHCN.8

Fathers Mental/Emotional Health. Among children in Delaware that lived with their father, 71.4% of fathers of CYSHCN were reported to have very good or excellent mental or emotional health. This compared to 82.2% of fathers of non-CYSHCN.8 //2012//

Current Priorities and Initiatives

The Family Health and Systems Management (FHSM) is currently working on a number of initiatives focused on improving Maternal and Child Health. The MCH Bureau is working with the University of Delaware to implement a statewide survey of families with children and youth with special health needs. The survey will be based on items from the National Survey of Children with Special Health Care Needs. The survey's results will provide evaluative data of our current efforts in enhancing supports for families with CYSHCN through the family support initiative. The Newborn Metabolic Screening and Newborn Hearing Screening Programs are working to create a data system and processes for follow-up. This follow-up will include the capacity to follow-up on interventions for birth defects, late onset hearing loss and possibly some metabolic disorders. Related to this system enhancement is an effort to increase reporting to the state's Autism registry. Reporting of autism and autism spectrum disorders is required by Delaware statute; however the system is currently underutilized. As the Healthy Women, Healthy Babies program completes its first full year, FHSM, through the Infant Mortality Elimination Program and the Center for Family Health Research and Epidemiology will measure and evaluate the behavior change that results from the array of interventions offered through this program, as well as health outcomes that may be captured. The Infant Mortality Elimination program is also launching a statewide preconception care social marketing campaign that includes promotion of a reproductive life plan.

A new initiative closely related to one of Delaware's State Performance Measures (decreasing the proportion of children at risk of developmental delays in early childhood) resides within the Early Childhood Comprehensive Systems (ECCS) program. In the proposed program, a child care health consultant (CCHC) will be a licensed or certified health professional (e.g. nurse, nurse practitioner, physician, health educator, oral health professional, and nutritionist) specifically trained to work with child care providers. Families depend upon child care businesses to meet their children's needs, anticipate problems and concerns, and to direct or refer families to needed resources. Other best practice state models use nurses, solely, to fill the role of the CCHC (e.g. Iowa and Illinois). As such, Delaware is proposing the Child Care Nurse Consultant (CCNC) program to provide the missing link and credibility for needed health, safety, and positive development in early care and education programs.

//2012/ In an effort to support the development of a comprehensive early childhood system that spans the prenatal-through-age-eight continuum, Delaware diverted resources from the proposed CCNC program to the development of a Help Me Grow system. In December 2010, Delaware applied for and was successfully awarded a Help Me Grow systems building grant through the W.K. Kellogg Foundation. In collaboration with several community based maternal and child health organizations, the DE-HMG will align with the federal and state's new priority to develop a comprehensive and integrated statewide system that acknowledges that children and their families are touched by sectors across health, education and social services. It is in the best interest of the children and families that we serve to find efficiencies that emphasize collaboration and adopt new approaches to program integration.//2012//

As a result of the 2010 Needs Assessment, and as described in greater detail in the 2010 Needs Assessment report, Delaware has identified 10 priorities specifically related to the Title V MCH Block Grant Program. These priorities are:

Reduce Infant Mortality. Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistently higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the Delaware Healthy Mother and Infant Consortium (DHMIC). The Consortium united with the DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached about 15% of all Delaware pregnancies in 2009. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007. The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

/2012/ New data shows that Delaware's state initiatives are proving successful in reducing Delaware's infant mortality rate. The state's infant mortality rate decreased for the third consecutive reporting period, dropping by 10 percent to 8.4 deaths for every 1,000 live births in 2004-2008 (compared to 6.8 deaths per 1,000 live births nationally). In the 2000-2004 reporting period, the state's infant mortality rate was 9.3 deaths for every 1,000 live births. Delaware's black infant mortality rate remains 2.6 times higher than the rate for whites and remains a prime focus of reduction efforts. The mortality rate for black infants for the period 2004-2008 is 15.1, compared to 5.9 for whites and 7.7 for Hispanics.

Healthy Women Healthy Babies, which was established in July 2009, addresses infant mortality head on by focusing on the lifestyle and environmental risk factors that may put women at greater risk of preterm labor and birth. Healthy Mothers Healthy Babies provides women at 17 sites statewide with the tools to maintain a healthy weight, eat a nutritious diet, include adequate amounts of folic acid, manage chronic disease, understand and mitigate environmental risk factors and work toward a tobacco- and substance-free lifestyle in addition to prenatal care. In 2010, the Healthy Mothers Healthy Babies program served more than 7,400 African-American women, women with health risk factors or whose most recent pregnancy resulted in a poor birth outcome. The program was recognized by the national Association of Maternal & Child Health Programs for providing evidence-based preventive services beyond the scope of routine prenatal care. More information on the program is featured at healthywomende.com

Another promising approach to help women in Delaware achieve healthier pregnancies and avoid preterm births and infant mortality is the development of Reproductive Life Plans for teens and adults, which are being distributed throughout the state. The Delaware Healthy Mother and Infant Consortium created the Reproductive Life Plan, per CDC's recommendations, into booklets in 2009 to serve as a tool. The plans contain information about avoiding pregnancy if desired, planning the spacing of pregnancies, preventing STDs, preparing for a healthy pregnancy, identifying unhealthy relationships, assessing and developing personal health goals, and communicating with health care providers.//2012//

Reduce the Incidences of Low Birth Weight Births and Preterm Births. Infant low birth weight is a

major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation. The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Delaware had the 11th highest preterm birth rate in the nation in the 2004-2008 period. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health. Interpregnancy intervals (IPIs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPIs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

Reduce the Prevalence of Child/Teen Obesity and Overweight. A child's weight status is determined based on an age-and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:

- Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
- Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

According to 2007 NSCH data, Delaware ranks 36 in overall prevalence with 33.2% of children considered either overweight or obese. Delaware's prevalence rank has changed since 2003, falling from a rank of 45. The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age). The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide. For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007. According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.

Reduce the Prevalence of Obesity Among Women of Childbearing Age. Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was \$117 billion, \$61 billion in direct cost, and \$56 billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as

increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

Reduce the Incidences of Unintentional Injury and Mortality among Children and Youth. The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years. Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

Reduce the Prevalence of Teen Smoking. Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days. These results parallel nationwide rates (50.3% of students nationwide tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data). Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days. In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years. Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.

/2012/ Maternal, Infant and Early Childhood Home Visiting Program. In July 2010, the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program awarded Delaware with a \$1,280,893 federal grant. Funds provide evidence-based home visitation services to improve outcomes for children and families residing in communities at high risk of public health problems such as infant mortality, premature birth, domestic violence, child maltreatment, poverty, crime and substance abuse. Delaware recently submitted its Updated State Plan outlining activities and strategies to demonstrate the program's effectiveness, and produce and measure positive impacts for children, their families and communities. Based on a thorough analysis, Healthy Families America, an initiative of Prevent Child Abuse America (PCA America), is the evidence-based home visiting model selected by Delaware for implementation. About \$673,000 of the ACA grant is allocated for Delaware Children and Families First, a non-profit organization that was an original Evidenced Based Home Visiting grantee through the Administration on Children and Families. DPH and several external partners are developing a continuum of home visiting services and a cross-organization approach to identifying and referring families for such services.

Public Health has long been a provider of home visits to pregnant women needing enhanced support and education to encourage successful pregnancy outcome, as well as prevent low birth weight and infant mortality. DPH has selected the nationally recognized Healthy Families America program to meld with the existing Delaware Smart Start program to target pregnant women living in specific areas of the state with high infant mortality rates. Healthy Families America (HFA) is an intense program of frequent visits during pregnancy and during the first six months postpartum, with extended support for parents to address their children's needs. Public Health staff are currently engaged in intense planning and are receiving training throughout the summer from the national HFA program to learn about the model, the outcomes expected, roles and responsibilities. While our current Smart Start services are continuing at this time, transition to the new model is expected in early 2012. //2012//

Enhance Family Support of Children and Youth with Special Health Care Needs. Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approach to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered -- it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

//2012/The Advisory Council members chose a new name for the Family Support Initiative at the April Advisory Council Meeting. The Family Support Initiative will now be known as Family SHADE, for Family Support and Healthcare Alliance DElaware. The next task is to develop a logo. Funds are available to post this task on www.crowdspring.com where artists would submit graphic designs and the Advisory Council would then select the winning entry. The Advisory Council agreed that Crowdspring worked well for the development of potential names and that it would worthwhile to try this route again.//2012//

Ensure the Early Detection of Developmental Delay. Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

Decrease Disparities among Families of Children and Youth with Special Health Care Needs. Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

Improve the Availability of Dental Services (Preventive and Treatment) for Children. Delaware is taking steps to reduce the shortage of oral health access. The DPH's Oral Health Program, the Delaware Dental Society, the Delaware Oral Health Coalition, and the Delaware Dental Hygienists Society all collaborate to provide support to increase access to dental prevention and treatment.

B. Agency Capacity

/2012/ Due to Character Limitations, the following is the remainder of the Section IIIA. Overview Section Narrative.

Determining the Importance, Magnitude, Value, and Priority of Competing Factors

As a Title V Maternal and Child Health Block Grant funded agency, the Delaware Department of Health and Social Services (DHSS), Division Public Health is required to conduct a comprehensive needs assessment every five years. Delaware's 2010 Needs Assessment serves as a road map to guide program activities, resource allocation and impact evaluation for programs and services that target MCH populations.

The goal of the needs assessment is to assess the health status of women, infants, children, adolescents, and CYSHCN through the lens of the most up-to-date epidemiologic data, evidence-based practice, and population self-reported needs. It also provides a framework for program activities by outlining state health priorities, indicators, objectives, and activities. The State of Delaware envisions the 2010 Needs Assessment as a living document for guiding and measuring programs and services over the next five years. As such, the Delaware 2010 Needs Assessment represents the first step in a cycle of continuous improvement of maternal, child, and adolescent health. Between 2010 and 2015, actions and strategies will be implemented, results will be monitored and evaluated under the State Performance Measures included in this application, and necessary adjustments will be made in an effort to enhance the health of women, children, and adolescents in Delaware.

The MCH Director (Ms. Alisa Olshefsky, MPH) led the Delaware 2010 Needs Assessment process. Ms. Olshefsky serves as the Chief of Family Health and Systems Management within the Delaware Division of Public Health. She began outlining the process and timeline for the needs assessment in March 2008. This included conducting a thorough environmental scan of all MCH programs and services DPH provided, either directly or indirectly. The scan also organized programs by the MCH service delivery pyramid (i.e. direct, enabling, infrastructure, or population-based service) and included information on the target populations, outputs, funding sources, evidence base for the program, and whether a formal evaluation had been conducted.

The Center for Family Health Research and Epidemiology (Center) within the Family Health and Systems Management Section conducted thorough reviews of the literature and provided epidemiologic analyses. The Center contracted with APS Healthcare to conduct epidemiologic research and evaluation that was beyond the capacity of Center staff.

Family leaders and advisors to the MCH Children and Youth with Special Health Care Needs Program were key in ensuring the MCH Needs Assessment Workgroup and process was inclusive of family input and insight. Over the course of six months, the workgroup maintained at least 25% representation of families at all meetings. This accomplishment was due to the outstanding work of Family to Family, a CYSHCN family-led organization through the University of Delaware, Center for Disabilities Studies.

In addition to family members, the composition of the workgroup (n=35) included executive leadership from DPH, program managers from Child Health, Early Childhood, State Systems Development Initiative, Newborn Metabolic Screening, Newborn Hearing, WIC, Immunizations, Adolescent and Reproductive Health, Primary and Rural Health Care, Health Statistics and staff from Community Health Services including Northern Health Services Clinics, Southern Health Services Clinics and the Oral Health Program. Representation from the Division of Child Mental Health Services, Children and Families First and the March of Dimes also participated on the workgroup.

A range of quantitative and qualitative resources were used to assess the strengths and needs of each of the MCH populations (infants, children ages 1-22, children and youth with special health care needs and pregnant women). Quantitative data collection included

meticulous searches through vital statistics, population-based surveillance, and program evaluation data. Qualitative data collection included structured interviews, surveys, and client observation.

Although all of the health priorities identified by stakeholders through the six-month assessment process are important, the MCH program and DPH do not have the capacity to address them all. In order to systematically analyze the Division's capacity, the workgroup chose to use the HRSA CAST-5 system. CAST-5 is a methodology for assessing an organization's capacity to carry out core MCH functions. The internal MCH Needs Assessment Workgroup was trained on the CAST-5 system then completed an assessment on each of the essential services process indicators. In groups of two or three members, the teams scored the level of adequacy and capacity needs. Rich comments were provided on each process indicator through a SWON (strengths, weaknesses, opportunities and needs) analysis. This process was conducted over three meetings for a total of 12 hours.

The state priorities identified in this application for the 2011-2015 cycle were derived from a consideration of existing capacity and a Q-sort procedure applied to a total of 33 health conditions or health problems. These procedures are described in detail in the 2010 Needs Assessment Report included with this application. Given the diversity in background of the workgroup members, it was important they all had a baseline understanding of the epidemiology, severity, causes and strategies for each of the 33 health problems. Thus, informational fact sheets were created and distributed for workgroup review. These were modeled on fact sheets created by similar Title V programs (such as the program in Minnesota). Members were divided into six teams and each team was given five to seven health conditions on which to focus. Each individual did a ranking worksheet on all 33 health conditions. Then, as a group, they developed one consensus ranking worksheet on the five to seven assigned health conditions. This dual approach of individual and group review allowed for all members to be engaged on each health condition while still focusing on those that most impacted/interested them. //2012//

State Program Collaboration and Coordination

The Title V Maternal and Child Health Program partners with numerous other state and community-based agencies to advance its mission to improve the health and wellness of preconception and pregnant women, children and children with special health care needs and their families. This collaboration takes place at a number of levels within the Family Health and Systems Management Section, as well as at the Division (Public Health) and Departmental (Health and Social Services) Levels.

At the highest level, health policy is driven by the Health Care Commission. The Delaware Health Care Commission embodies the public/private efforts which have traditionally spelled success for problem solving in Delaware. Four government officials -the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families and the Insurance Commissioner -are joined by six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors. By creating the Commission as a policy-setting body the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. The Commission is expressly authorized by statute to conduct pilot projects to test methods for catalyzing private-sector activities that will help the state meet its health care needs. To achieve its goals, the Commission strives to balance various viewpoints and perspectives.

The Commission generally has followed a strategy built on the notion that initial efforts should

target areas most in need and gradually build toward a more comprehensive plan. Since 1995, the Commission has used a committee system as a means of reaching out to the community and involving those impacted by its decisions in the consensus building process.

The leadership of the Division of Public Health is also served by a number of advisory committees/councils that provide input on a variety of health topics. Specific to Maternal and Child Health are two committees --the Delaware Healthy Mothers and Infants Consortium, a governor appointed body charged with the reduction of infant mortality and the Teen Pregnancy Prevention Advisory Committee, a body appointed by the Director of the Division of Public Health. Staff from Family Health and Systems Management, including the Maternal and Child Health Bureau provide staff and logistical support to both of these committees.

Under Family Health and Systems Management leadership there are committees that are specifically charged with issues affecting Children with Special Health Care Needs (Coordinating Council for Children with Disabilities; Family Support Network), early childhood (Early Childhood Comprehensive Systems Advisory Committee); newborn bloodspot screening (Newborn Screening Advisory Committee), newborn hearing screening (Delaware Hearing Assessment and Intervention Program Advisory Board), and the birth defects and autism registries (Birth Defects and Autism Registry Advisory Board).

Each of these committees consist of representatives from community-based agencies, other state agencies and family members of affected populations and provide critical input into MCH-related programs and activities.

Preventive & Primary Care Services for Pregnant Women, Mothers and Infants

Currently, preventive and primary care services for pregnant women, mothers and infants are supported through Title V Maternal and Child Health Block Grant and state general funds in statewide programs for pregnant women, women of reproductive age, infants, children and adolescents. Historically, these programs have included the home visiting programs Smart Start and Kids Kare. Smart Start is a prenatal program for at-risk pregnant women and Kids Kare provides support for families with children who are at risk for delayed development. These programs are currently being merged into a new evidence-based program model under the Healthy Families America framework, Smart Start which will serve at-risk pregnant women and children.

Over the past, the Family Practice Team Model and the Preconception Care Program have been merged into Healthy Women, Healthy Babies, a program that serves women at the preconception, prenatal and interconception periods. In this program, women are screened for risk factors in four domains: nutrition, social, mental health and medical. Once enrolled, pregnant women are seen at least monthly throughout their pregnancy and depending on their risk factors, provided information and education on topics including domestic violence, reproductive health, labor and delivery, alcohol, substance and tobacco use, and post partum issues.

Other programmatic efforts that offer preventive and primary care services for women and infants include WIC, Family Planning, and services offered on-site at Public Health clinics throughout the state.

As part of the research completed in the design and implementation of both the Family Practice Team Model and Preconception Care programs, the State of Delaware created a Registry for Improved Birth Outcomes. The registry, compiled from all births in Delaware occurring over during the past two decades, has helped to identify key risk factors associated with poor birth outcome (prematurity, low-birth weight and infant mortality). These factors include smoking, maternal weight (either too low or too high), chronic disease and short intervals between pregnancies.

The Newborn Metabolic Screening Program offers initial and confirmatory (second) screening for 37 conditions for every infant born in Delaware. The Newborn Metabolic Screening program also

offers follow-up case management of positive screens to ensure identified infants and their families are linked to appropriate treatment services.

In the Spring of 2010, DHHS Secretary Sebelius released recommendations to screen for 30 core conditions. Currently, Delaware screens for 29 of these conditions. The one condition that is not currently included in Delaware's 37 conditions is Severe Combined Immunodeficiency Disease (SCID). In June of 2010, the state's Newborn Screening Advisory Council recommended that Delaware should investigate SCID screening, costs, equipment and staffing requirements. A final decision on this matter is expected later this year.

/2012/ SCID is a group of disorders characterized by a deficiency of the immune system, affecting approximately one in 100,000 newborns. Infants affected by SCID develop recurrent infections leading to death in early childhood. Treatment in the first months after birth can prolong life and prevent infections. The newborn screening test that suggests the presence of SCID can also detect a number of other congenital disorders of the immune system. Recently the U.S. Secretary of Health and Human Services' advisory committee on Heritable Disorders in Newborns and Children (SACHDNC) recommended that states add SCID testing to their newborn screening panel. The Delaware Newborn Screening Program Advisory Committee endorsed this recommendation with the support of national organizations, parents of children with SCID, and pediatricians. The DPH Director agreed to the recommendations on February 22, 2011. SCID testing will begin in the DPH laboratory pending staff training, equipment delivery and the implementation of supporting data systems. In a joint effort between the Public Health Lab and Maternal and Child Health, a Press Release was written and released in April 2011 sharing information on the addition of SCID testing to the Newborn Screening Program. Quotes were obtained from the Director of DPH, a parent of two children with SCID and the Governor. //2012//

The Newborn Hearing Screening Program offers universal screening. Currently, the program screens over 93% of infants born in the state. The program also manages a hearing aid loaner program for children until a source is identified to obtain their own hearing aid.

Services for CSHCN

In Delaware, Children with Special Healthcare Needs (CSHCN) are served by the Birth to Three program for infants and toddlers aged 0-3 and by Kids Kare for children to age 21. The mission of the Birth to Three Early Intervention System is to enhance the development of infants and toddlers with, or at risk for disabilities or developmental delays, and to enhance the capacity of their families to meet the needs of their young children. Child Development Watch (CDW) is the statewide early intervention program under the Birth to Three Early Intervention System. CDW is a collaborative effort with staff from the Division of Public Health, the Department of Services for Children, Youth and Their Families, the Department of Education and the Alfred I. DuPont Hospital for Children working together to provide early intervention to young children with special health care needs and their families.

CDW is evaluated on an ongoing basis. One of the evaluative tools is the annual Family Survey which is conducted via telephone with a stratified random sample of families based on geographic region, ethnicity and length of time in the program. The 2007 survey found: -97% of families indicated that they had overall satisfaction with the services they received; -94% of families perceived the program as accessible and receptive; -93% of families perceived change in themselves and their family; -93% of families perceived change in their child; -93% of families reported a positive perception of family decision-making opportunities; -92% of families reported a positive family-program relationship with CDW staff; and, -92% of families reported a positive perception of their quality of life.

The Child Development Watch (CDW) Program provides developmental assessments to children

birth to 3 years of age and service coordination for developmental services and therapies. According to an annual University of Delaware survey, 95.9% of families perceived the CDW program as accessible and receptive, while more than 92.5% perceived change in their child's abilities. As of the end of FY09, CDW has case managed 3,094 children statewide; 1,875 are served by the NHS' CDW office. An additional 124 children will be re-evaluated.

CDW strives for compliance with federal timelines despite high caseload numbers. This year, CDW North achieved 90% for providing services within 30 days. In a study sample of 236 children, 78% of CDW children with skills below age expectations made gains by their discharge date. Forty-seven percent of these children are functioning at age level upon discharge.

CHILD DEVELOPMENT WATCH (CDW) RECOGNITION --Southern Health Services' Child Development Watch (CDW) staff surpassed their federal 45-day timeline standard from date of referral to delivery of individual family service plans (IFSP) by reducing the interval to 39 days by year's end. While 55% of the Family Service Coordinators were compliant at the beginning of 2009, 83% attained this standard by December. Success is correlated with the systematic implementation of individual and group data feedback provided by the management analyst and supervisors.

CDW PROGRAM AWARENESS --Dr. Carol Owens, Developmental Pediatrician, and Jennifer Donahue, Trainer/Educator, formed a professional outreach committee to encourage physician referrals to the CDW Program. They provided Kent and Sussex County physicians with resources, information and opportunities for collaboration. A practice can elect to receive one or all of the following: a CDW Program manual; one-on-one or group training; one-time contact or monthly contact to discuss referrals. To date, response is lower than expected. New approaches are being considered.

The Office of Children with Special Health Care Needs, as part of Delaware's Maternal and Child Health program in the Division of Public Health, has a long history of family/professional partnerships by working closely with families and family-led organizations. Since 1993, Delaware's Birth to Three system in coordination with the Office of CSHCN have developed practices of family-centered care that have become part of the culture for DPH in addressing the needs of families of young children with special needs.

Child Development Watch utilizes a community team model. The CDW team includes members from the Division of Family Services, the Division of Management Services, the Department of Education, the Division of Developmental Disabilities Services and contractual staff to ensure children and families are linked with the appropriate array of services. The model also includes specialized community services provided in early education centers and daycare settings, where CDW provides outreach to care providers for educational purposes and follow-up services for Children with Special Health Care Needs.

Current efforts to provide coordination to youth transitioning to adult services include Delaware's Transition Initiative that sponsored a survey of youths moving to adult services in the community. Based in part on the research that found youth have difficulty securing specialty care in the adult community, A. I. duPont Hospital for Children of the Nemours Foundation has created an Office of Transition and clinical team to meet the needs of youth transitioning to adult community services. The Office of Transition team includes a nurse, a part-time medical doctor, a social worker, and support staff. It will be operational in summer, 2008. In addition, the Office of CSHCN also supports expansion of Internet based tools for families and youth with special health care needs. Through a contract with the University of Delaware's Center for Disability Studies, Delaware's website for transition information continues to be updated to include specific contact information for medical and social needs.

Cultural Competence

In 2007, the Delaware Division of Public Health (DPH)/DHSS contracted with the Center for Health Equality (CHE) at Drexel University's School of Public Health to conduct a cultural competence assessment of the division. The primary project objective was to apply a health care cultural competence protocol that was adapted, with the assistance of DPH staff, to the priorities and characteristics of the division. The process called for interviewing administrative, management and program personnel identified by the DPH, obtaining and ordering cultural competence-related materials across programs, and scoring and scaling the division according to the assessment's five-point "Spectrum of Cultural Competence."

In addition to the relative strengths of DPH in striving for cultural competence, the report identified areas for improvement. These areas include: -Services tend to operate independently of each other and, as a result, there was little opportunity to engage across them or to learn from their experiences or initiatives. -Insufficient resources to provide important cultural competence services, including restrictions and requirements regarding dollar allocations, limit scope and reach and make it difficult to prioritize cultural diversity given other pressing needs. -From staff in administration and direct service there was very little to no information gathered related to a formal process for collecting and monitoring client based race and ethnic data. Direct service staff do not have a formal mechanism for capturing client language needs in electronic databases. Although individual programs have added this information to their intake questionnaires, these data are not captured for administration to observe trends in demographic shift of clients. - Although, there were many connections to the community, most of the work to incorporate community was project specific and oriented toward direct service personnel. To address these challenges, the DPH Office of Minority Health and the Office of Workforce Development have developed an ongoing training half day training, "DPH: Journey to Cultural Competence." The training is filled with rich discussion and interactive activities to help DPH employees increase cultural awareness to better serve our customers, clients, patients and co-workers. In 2009, approximately 163 professionals attended the training and gave overwhelmingly positive evaluations.

In 2008, the Office of Minority Health released a Health Disparities Report Card that was designed to show the health disparity gaps among Delaware's racial and ethnic minorities, and to help monitor the community's and state's progress in eliminating those gaps.

Leading health and related indicators for broad racial and ethnic populations were included, along with supporting data and a letter grade to rank the health status of those groups.

This report card's aims are to:

- Inform the public and professionals, helping to guide them as they develop strategies, plans and programs to eliminate health disparities;
- Provide data to guide services and outreach provided by community-based organizations, faith-based organizations, state agencies and organizations, legislators, businesses, health care providers and hospitals; and
- Inform key decision makers on eliminating health disparities through policy reform and systems change.

Recent Legislation (2009-2010)

In the current legislative session ending 6/30/2010 several notable bills were signed into law.

House Bill #44. This bill authorized the State Fire Prevention Commission to incorporate a non-profit, non-stock corporation known as the Delaware Burn Camp Corporation for the purpose of establishing, administering and operating an overnight camp devoted to helping burned children cope with the emotional and physical issues from their injuries.

House Bill # 328. This bill requires courts, administrative tribunals, school districts, and schools to

use the definition of "free and appropriate education" with respect to disabled children that has been enumerated for this region of the country by the United States Third Circuit Court of Appeals in *Ridgewood Board of Education v. N.E.*, 172 F.3d 238 (3d. Cir. 1999).

Free appropriate public education' means special education that is specially designed instruction including classroom instruction, instruction in physical education, home instruction and instruction in hospitals and institutions, and related services as defined by Department of Education rules and regulations approved by the State Board of Education and as may be required to assist a handicapped person to benefit from an education that:

- a. Is provided at public expense, under public supervision and direction and without charge in the public school system;
- b. Meets the standards of the Department of Education as set forth in this title or in the rules and regulations of the Department as approved by the State Board;
- c. Includes elementary, secondary or vocational education in the State;
- d. Is individualized to meet the unique needs of the handicapped person;
- e. Provides significant learning to the handicapped person; and
- f. Confers meaningful benefit on the handicapped person that is gauged to the handicapped person's potential.

Delaware's Children's Health Insurance Program (CHIP) was extended to include reduced-cost health insurance coverage for children of families with personal incomes above 200% of the Federal Poverty Level.

A law requiring the developmental screening of infants and toddlers has been signed. This law equires that private health insurers in Delaware cover the developmental screenings for infants and toddlers that are recommended by the American Academy of Pediatrics and the Delaware Early Childhood Council. Such screenings have historically been covered for children in the state's Medicaid program. The estimated cost to policyholders of covering these screenings is three cents per member per month.

A law to expland access to dental care for children with disabilities was signed. Parents of children with severe disabilities experience difficulty in identifying practitioners willing and able to provide effective dental care. Strict application of "in-network" insurance restrictions exacerbates the parents dilemma since there may be no nearby in-network dentist willing and able to treat their child. When parents with secondary child Medicaid insurance are unable to effectively access private dental insurance, the result is an increase in Medicaid claims. This bill only applies to insurers which include dental services in their benefits package. It allows parents with such private dental insurance to secure dental care for a child with a severe disability irrespective of "in-network" restrictions. Finally, it promotes the availability of in-network practitioners willing and able to treat such children.

On June 30, 2010, House Bill 283 was sent to the Governor and is awaiting signature at the time of submission of this application. HB 283 creates a "Hearing Bill of Rights" for school-aged children who are deaf or hard of hearing. Specifically, the bill allows deaf and hard of hearing children to receive instruction in more than one communication mode or language.

//2012// In the current legislative session ending 6/30/2011 several notable bills were signed or are expected to be signed into law.

SIGNED - HB 3 w/ HA 1 Bans Trans Fats in Schools. To combat childhood obesity, this Bill prohibits public schools, including charter schools, and school districts from making available or serving food with more than 0.5 gram of artificial trans fatty acids to students in grades K through 12. The Amendment clarifies that not only is a school prohibited from serving food to students containing industrially produced trans fat, a school is also prohibited from using food containing industrially produced trans fat in the preparation of a food item for such students.

To Governor for Signature - HB 91 People First Language (PFL) PFL legislation is part of a national movement to promote dignity and inclusion for people with disabilities. PFL specifies that the order of terms used to describe any individual places the person first, and the description of the person second. For example, when using PFL, outdated terms such as "the disabled" would be phrased as "people with disabilities."

To Governor for Signature - HB 141 DSCPD Brain Injury Council The Delaware State Council for Persons with Disabilities (DSCPD) has informally maintained a 24-member brain injury committee since 2003. This bill would amend the Council's enabling statute to confirm its status as the State's primary brain injury council, clarify the role and membership of its brain injury committee, and enhance prospects for acquiring competitive grant funds. The bill also maintains a standing brain injury committee to facilitate prevention and centralized interdisciplinary planning, assessment and an improved service delivery system for individuals with brain injury comprised of the following members, or designees of such members: Director of the Division of Public Health. //2012//

C. Organizational Structure

Governor Jack Markell heads the executive branch of Delaware's state government. The Delaware Department of Health and Social Services (DHSS) is among the cabinet-level agencies in the executive branch. DHSS is led by Secretary Rita Landgraf.

The Delaware Department of Health and Social Services is the largest state agency, employing almost 5,000 individuals in a wide range of public service jobs. The department includes 12 divisions, which provide services in the areas of public health, social services, substance abuse and mental health, child support, developmental disabilities, long term care, visual impairment, aging and adults with physical disabilities, and Medicaid and medical assistance. The Department includes four long term care facilities and the state's only psychiatric hospital, the Delaware Psychiatric Center.

The Division of Public Health is the largest division within DHSS and is under the direction of Karyl T. Rattay, MD. In Delaware, there are no county/local health departments. DPH administers both state and local public health programs. DPH is structured into three main strands: Operations, Health Information and Science (HI&S), and Community Health Services. The Title V Maternal and Child Health (MCH) Block Grant program and the Children with Special Health Care Needs (CSHCN) program are part of the Family Health and Systems Management Section (FHSM), within the HI&S strand. HI&S is led by Paul Silverman, Dr.PH. Alisa Olshefsky, M.P.H. is the section chief for FHSM, as well as the state MCH Director. Within FHSM, the Bureau of Maternal & Child Health is led by the MCH Deputy Director, Leah Jones, MPA. The Bureau includes the Title V Block Grant, the Newborn Screening program, the Newborn Hearing program, the Genetics program, Early Childhood Comprehensive Systems, and the State Systems Development Initiative, and Children with Special Health Care Needs. The Bureau of Adolescent and Reproductive Health, under Gloria James, Ph.D. includes the Adolescent Health Program (which includes School-Based Wellness Centers and Teen Pregnancy Prevention) and the Title X Family Planning Program. The Bureau of Health Planning & Resources Management, led by Judith Chaconas includes the Offices of Primary Care & Rural Health and the J-1 Visa program. The Center for Family Health Research and Epidemiology, led by Mawuna Gardesey, M.B.A. includes the Infant Mortality Elimination Program. (See attached Organization Chart).

Nurses, social workers and nutritionists within the Smart Start, Kids Kare, and Child Development Watch Programs are directed by Herman Ellis, MD and Kristin Bennett, RN., MSN. Beyond the FHSM section, several other critical programs are part of the MCH array of services and programs. These include Oral and Dental Health Services; Northern Health Service Clinics, led

by Anita Muir, M.S.; and Southern Health Clinics, led by Sherry Eshbach. Northern and Southern Health Services Clinic sites are the providers of three primary programs funded by Title V funds: Smart Start, Kids Kare (currently being integrated into Smart Start) and Child Development Watch. The state Public Health Nursing Director is Kristin Bennett, PhD., RN. DPH also includes a number of other programmatic areas which work closely with the MCH array of programs and activities. These programs are located throughout the strands of DPH and include Immunizations, Sexually Transmitted Diseases, Emergency Medical Services for Children, and the WIC program.

The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes \$1,814,303 for 29.4 FTEs (2.0 FTEs are projected to remain vacant during FY 2010). State general funds and appropriated special funds from Oral Health revenue will pay for 72.0 FTEs (a total of \$4,989,395) and contractual funds under the Infant Mortality Elimination program (a total of \$4,600,000).

***//2012/ The total Maternal and Child Health Partnership budget reported in this application includes Title V funds, state general funds and appropriated special funds. Staff are funded through each of the three sources of funds. This year's Title V funds includes \$1,557,202 for 24.4 FTEs (2.0 FTEs are projected to remain vacant during FY 2012). State general funds and appropriated special funds from Oral Health revenue will pay for 63.5 FTEs (a total of \$4,430,585) and contractual funds under the Infant Mortality Elimination program (a total of \$4,600,000). //2012//
An attachment is included in this section. IIIC - Organizational Structure***

D. Other MCH Capacity

Senior level / lead staff for the MCH Block Grant are:

Alisa Olshefsky, MPH. Alisa serves as the state Maternal and Child Health Director and is the Section Chief for Family Health and Systems Management. Alisa is in her third year serving in these capacities. Prior to assuming section chief responsibilities at the Division of Public Health, Alisa served as a Bureau Chief for Chronic Disease from 2006-2008 where she built and sustained the Delaware Cancer Consortium, a public/private collaborative. Alisa also has past experience as an Evaluation Manager at the University of California (San Diego), Division of Community Pediatrics.

Leah A. Jones, M.P.A. is the Maternal and Child Health Bureau Chief and MCH Deputy Director. Leah is responsible for direct oversight of the Title V Maternal and Child Health Block Grant Program, the State Systems Development Initiative, the Children with Special Health Care Needs Program, Early Childhood and Comprehensive Systems, the Autism Registry and the Birth Defects Registry and the Newborn Screening Programs (Metabolic and Hearing). Leah joined the Division of Public Health this year in the Spring. Leah's prior experience includes serving as the Director of Planning & Policy for the Delaware Health Care Commission. In the past administration, Leah worked as the Executive Assistant to Cabinet Secretary of Delaware Health and Social Services. Leah also served as the Caregiving Program Administrator for the Division of Services for Aging and Adults with Physical Disabilities.

//2012/ Delaware recognizes the importance of achieving a family-centered system of services for children and youth with special health care needs and their families, and is very pleased to report that in June 2011, DPH was approved to recruit candidates for the Children with Special Health Care Needs Director position within the Maternal and Child Health Bureau. The incumbent in this position will oversee the Children and Youth with Special Health Care Needs program (CYSHCN). Duties include: creating a system that allows families to partner in decision making and improving the services they receive, enhancing medical provider capacity regarding access to a medical home, ensuring adequate health insurance is available to pay for needed services, improving early

identification of CYSHCN through enhanced developmental screening and awareness, and improving access for families to reliable information, resources and quality services. //2012//

Parents of Children with Special Needs. Beth MacDonald, a CSHCN parent, is the Special Needs Alert Program (SNAP) program coordinator. Additionally, the MCH Program works closely with Family 2 Family, Delaware Family Voices, Delaware Hands and Voices and each of the organizations involved with the Family Support Initiative to ensure parent / family involvement in planning and evaluation of initiatives focused on Children with Special Health Care Needs.

/2012/ Investing in our best and brightest, including new and seasoned personnel as well as our key partners is critically important. Over the last year, we have focused on building leadership skills and competencies in Maternal and Child Health.

Alisa Olshefsky, MCH Director, participated in the MCH-Public Health Leadership Institute, which is designed to significantly expand self-awareness, build practical skills for effectively leading, managing people, and building partnerships, to advocate for and create MCH systems improvements.

Ann Phillips, Director of the Family Voices' Family to Family Health Information Center, and a key Title V MCH partner and family leader, was also recently accepted into the MCH-Public Health Leadership Institute.

In December 2010, Leah Jones Woodall, MCH Deputy Director, was accepted into the AMCHP New Director Mentorship Program. Ms. Woodall was matched with Valerie Ricker, Director of the Family Health Division in the State Maine. The program is a great opportunity that matches experienced Title V Directors with new MCH Directors to help develop his or her goals and skills over 12 months through one on one conversations, learning activities and interactive online learning modules.

Walt Mateja, PhD, the Child Health Branch Director, competitively applied to the 2011 Training Course in Maternal and Child Health Epidemiology and was accepted. Dr. Mateja attended the training course in May 2011. The course provided states with an opportunity to build capacity for Maternal and Child Health Epidemiology. The training covered an in-depth description of the needs assessment-program evaluation cycle. The course also covered several approaches to identifying appropriate numeric targets for performance measures. Along with other State personnel, Dr. Mateja was afforded the opportunity to apply key concepts to practical case studies throughout the course. Knowledge and skills gained from this training will be applied within the Delaware Division of Public Health's Title V programs (Newborn Screening, Early Childhood, Children with Special Health Care Needs and Maternal and Child Health).

In the Spring 2011, Delaware applied for Technical Assistance through the HRSA MCHB to provide two workshops, one that covered strategic planning and a second on grant proposal writing. The Family Support Initiative conducted an environmental scan in August 2010 of 44 community based organizations and agencies who serve CYSHCN. As part of this scan, organizations were asked what technical assistance would be beneficial to their organizations, which 68% of the organizations indicated that technical assistance in the area of grant writing would benefit their organization. This TA opportunity provided Maternal and Child Health staff and key partners of the Family Support Initiative participating to focus on sustainability and capacity building. In addition, the TA served as a tool to plan programs and services as well as assess and plan for short and long-term financial stability to provide services. //2012//

Staff Dedicated to the Maternal and Child Health Block Grant

Staffing for the Title V programs includes 29.9 FTEs supported with Federal Title V funds and 72 FTEs supported by State General Funds (65 FTEs) and Appropriated Special Funds (7.0 FTEs).

Positions included as part of the Federal-State MCH Partnership are distributed as follows:

- 10 Administrative Specialists
- 10.5 Advanced Practice Nurses
- 1 Section Chief (MCH Director)
- 1 Clinic Aide
- 4 Clinic Managers
- 1 Community Relations Officer
- 9 Dental Assistants
- 6 Dentists
- 1 Genetics Coordinator
- .5 Health Program Coordinator
- 1 Management Analyst
- 3 Medical Records Technicians
- 1 Medical Social Worker Consultant
- 7 Nursing Supervisors
- 1 Nutritionist
- 3.0 Public Health Program Administrators
- .4 Public Health Physician
- 17.5 Registered Nurses
- 2 Senior Child Development Specialist
- 5.0 Senior Medical/Social Work Consultants
- 1 Social Worker
- 4 Social Service Specialists
- 8 Social Service Technicians
- 1 Teacher
- 1 Teacher's Aide
- 2 Trainers

These positions are located throughout the state's 9 Public Health Clinic Locations and work primarily in Smart Start, KIDS Kare, Child Development Watch and the Oral Health Program. Several positions (Program Administrators, Management Analyst, Section Chief) are centrally located in the DPH Administration Building in Dover, DE.

/2012/ Staffing for the Title V programs includes 24.4 FTEs supported with Federal Title V funds and 63.5 FTEs supported by State General Funds (56.5 FTEs) and Appropriated Special Funds (7.0 FTEs).

Positions included as part of the Federal-State MCH Partnership are distributed as follows:

- 11 Administrative Specialists***
- 9.5 Advanced Practice Nurses***
- 1 Section Chief (MCH Director)***
- 1 Clinic Aide***
- 4 Clinic Managers***
- .5 Community Relations Officer***
- 8 Dental Assistants***
- 5 Dentists***
- .5 Health Program Coordinator***
- 1 Management Analyst***
- 3 Medical Records Technicians***
- 1 Medical Social Worker Consultant***
- 4 Nursing Supervisors***

- 1 Nutritionist
- 2.5 Public Health Program Administrators
- 1.4 Public Health Physician
- 11.5 Registered Nurses
- 2 Senior Child Development Specialist
- 5 Senior Medical/Social Work Consultants
- 1 Social Worker
- 3 Social Service Specialists
- 6 Social Service Technicians
- 1 Teacher
- 1 Teacher's Aide
- 2 Trainers
- 1 Operation Support Specialist

These positions are located throughout the state's 9 Public Health Clinic Locations and work primarily in Smart Start, KIDS Kare, Child Development Watch and the Oral Health Program. Several positions (Program Administrators, Management Analyst, Section Chief) are centrally located in the DPH Administration Building in Dover, DE. //2012//

E. State Agency Coordination

Delaware prides itself in building and maintaining partnerships and collaborations with both state and federal organizations. Many organizations and coalitions are working to improve maternal and child health in the state of Delaware. Within DPH, a performance improvement initiative led by the Division Director is re-focusing the organizations priorities to focus on core services within public health and specific health priorities. The aim is to have DPH working at the "bottom of pyramid" on population-based and infrastructure-building services. The four Division priorities include:

- Healthy lifestyles
- Health reform
- Disparities elimination
- Organizational development

These priorities are addressed in part through the following relevant relationships between the Division of Public Health/Title V MCH Program and external partners.

Delaware Healthy Mother and Infant Consortium. The targeted effort of providers, DPH, and the Delaware Healthy Mother and Infant Consortium (DHMIC) and its subcommittees to reach pregnant women and mothers is very successful. In 2008, the prenatal programs reached almost 20% of all pregnancies in Delaware.

Child Death, Near Death and Stillbirth Commission (CDNDSC). Delaware's child death review process was established by legislation passed on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The statute was amended in 2002, and again in 2004, changing the name from the Delaware Child Death Review Commission to the Child Death, Near Death and Stillbirth Commission (CDNDSC). The mission of the commission is to safeguard the health and safety of all Delaware children as set forth in 31 Del. C. c. 3. The key objectives are:

- Review in a confidential manner, the deaths of children under the age of 18, near-deaths of abused and/or neglected children and stillbirths occurring after at least 20 weeks of gestation.
- Provide the Governor, General Assembly and Child Protection Accountability Commission with recommendations to alleviate those practices or conditions that impact the mortality of children.
- Assist in facilitating appropriate action in response to recommendations.

The CDNDSC has the authority to create up to three regional child death review panels and three

regional Fetal Infant Mortality Review (FIMR) teams to conduct retrospective reviews of all child deaths, near deaths due to abuse/neglect and stillbirths (after 20 weeks gestation) that occur in the state. The Commission provides meaningful system-wide recommendations to prevent the deaths and/or near deaths of children and improve services to children. The process brings professionals and experts from a variety of disciplines together to conduct retrospective case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

CDNDSC/Fetal and Infant Mortality Review. Reviews every fetal and infant death in Delaware using the Fetal and Infant Mortality Review (FIMR) process, which includes reviewing medical records, death certificates and other health information, and interviewing mothers. FIMR helps to inform why there is a high number of fetal and infant deaths in Delaware. The information received from interviews with mothers helps make recommendations for changes in public health programs and interventions.

The top four issues identified in 2008-2009 were:

- preexisting medical conditions;
- medial and social services and community resources that were available and not used;
- obesity and poor nutrition;
- preterm labor.

More specifically, 71 percent of women interviewed had a preexisting medical condition, 40 percent had inadequate or delayed referrals for home-based services; 26 percent were obese and 24 percent had inadequate nutrition or anemia in the first trimester; and 32 percent went into preterm labor.

The DHMIC is the community action arm or implementation teams for FIMR findings.

In 2010 CDNDSC is collaborating with the Division of Public Health and Nemours to implement the National "Cribs for Kids Program" in Delaware. This program provides cribs and educational materials related to safe sleeping practices to mothers in need.

FIMR Infant Safe Sleeping Practice. In 2009: FIMR distributed Infant Safe Sleeping Posters to all licensed daycare centers in the state and continued community education on Safe Sleeping Practices as community events/trainings.

Delaware Birth Defects Registry. A statewide program that collects and analyzes information on children with birth defects. By collecting information for a statewide registry, Public Health officials hope to identify health, environmental and genetic risk factors which could lead to pinpointing the causes and prevalence of birth defects. The Delaware Birth Defects Registry is designed to collect information on children diagnosed under the age of five with a birth defect. The children are residents of Delaware or their parents are Delaware residents. Confidentiality is a key component of the program. All information is kept in utmost confidence using strict security measures.

March of Dimes. The March of Dimes-Delaware Chapter (MOD) works to improve the health of babies by preventing birth defects, prematurity and infant mortality. The mission is accomplished through research, community services, education and advocacy and collaborations with many organizations to save babies' lives. Delaware's MOD also is one of 15 chapters to support the NICU Family Support Program which provides direct service and support to families with infants in the NICU of Christiana Care. Through partnership, families are directly linked to community programs to assist with transition from hospital to home for the most vulnerable babies prior to discharge. DPH will continue to collaborate with the March of Dimes in a joint effort to increase access to quality prenatal care, reduce the number of premature births and birth defects and improve health outcomes of all children. The MOD staff serve on DHMIC committees.

Department of Education (DOE). The Delaware Health and Social Services and the Department

of Education work collaboratively to develop programs promoting the health of all children in Delaware. Examples include the delivery of EPSDT services in the school setting and in providing support for School-Based Health Centers. Currently there are commissions on Health Education, Health Services, and Physical Education, Nutrition Services, School Climate, Staff Wellness, and Counseling Services. The Coordinated School Health Program Team is composed of a variety of health and education related agencies, private, and public including parents. They recruited school applicants to participate in a needs assessment of health needs in their respective schools. After identifying the specific needs, plans were developed to target those needs. The DOE has also collaborated with DPH in development of the Part C early intervention efforts. Staff are also housed and incorporated into the CDW team and serve as liaisons for transition and Individuals with Disabilities Education Act (IDEA B and C) issues. The Office of Health Services, DOE, in partnership with the DPH provides training to school nurses on teen pregnancy prevention, lead poisoning, tuberculosis, immunizations, bio-terrorism and emergency preparedness and public health resources. Delaware has a comprehensive system of school nurses, with one in each school and most private schools. There are over 320 full and part time school nurses in Delaware that serve students in public and private schools.

Head Start and Early Childhood Assistance Program. Head Start is administered by DOE through community-based organizations throughout the state. There are three locations in Kent County, four in Sussex County, and twelve in New Castle County. Early Childhood Assistance Programs are state-funded, comprehensive child development programs for low-income families with children age four and eligible for kindergarten the following year. These programs follow the Head Start Performance Standards. Approximately 1,795 children between ages three and five are served by the traditional Head Start program. All programs followed the federal Head Start Performance Standards. The Division of Public Health participates on the Head Start State Collaboration project, which was established to develop state level partnerships for planning and policy development for Head Start eligible children and their families. Priority areas include welfare reform, health access, childcare, social and emotional wellness, disabilities, educational opportunities, volunteerism, literacy, and homelessness. The Head Start State Collaboration Office director serves on the ECCS steering and executive committees and Healthy Child Care America-Delaware (HCCA-DE) advisory committee. HCCA-DE and the Head Start State Collaboration Office partnered to provide funding and resources for the piloting of Partners In Excellence: Promoting Social & Emotional Competencies in Young Children (PIE) in 15 Head Starts, ECAPS and Child Care Centers statewide. An additional partner is the Devereux Foundation and one of the evaluation measures will utilize the Devereux Early Child Assessment (DECA) tool. This pilot worked with classroom teachers and parents to infuse PIE and DECA strategies into classroom curriculum to identify and minimize challenging behaviors. The pilot utilized child care health consultants as technical advisors in the classroom setting and will impact over 1500 children, between the ages of 3 to 5. In addition, Child Development Watch staff work with local Head Starts and other providers on the Sequence in Transition to Education in Public Schools (STEPS) Committee, which concentrates on transition issues for 3 year olds.

Early Success. The Department of Education's Early Care and Education Office is a key collaborator with the Division of Public Health on the early childhood comprehensive systems effort. Initiated in 1998, Early Success was developed as the state's coordinated plan to address the early childhood issues of children, birth to eight, who received out of home care. The governor established an interagency resource management committee made of the cabinet secretaries from the Department of Health and Social Services, Department of Services to Children, Youth and their Families, Department of Education, Office of Budget, and the Controller General's Office. Additionally, the governor established the Delaware Early Care and Education Council, comprised of private citizens, and the Office of Early Care and Education (OECE) to ensure that Early Success goals and objectives were met. In an effort to provide a comprehensive approach of early childhood services to all families, the ECCS and the OECE, with full support from the Delaware Early Care and Education Council, have partnered to unify Delaware's early childhood initiatives and broaden the initial Early Success plan to include child health, social-emotional development, and expand family engagement domains. This will provide

a statewide strategic plan that is comprehensive, coordinated and accessible to all children from birth to age five, and their families. It will also enable the DPH to provide statewide leadership on child health and development issues through multiple public/private collaborations.

Early Childhood Work Groups. The Early Childhood Education workgroup provides leadership to ensure that Delaware delivers an equitable and effective system of education for young children in full compliance with federal and state law. The group ensures that the interests of young children are represented in all aspects of Delaware's education reform. The group operates, oversees and monitors programs made possible by both federal and state funds.

The School Support Services workgroup includes programs and support services necessary to assure a supportive and healthy environment that nurtures academic growth and development. The group is responsible for the development of programs and services in the areas of:

- Nutrition Programs;
- School Climate and Discipline;
- School Health Services;
- Student Services and Special Populations.

Delaware Oral Health Coalition. Promotes good oral health through its Awareness and Prevention Committee and its Integrated Delivery Systems Committee. The Coalition was instrumental in developing the Oral Health Awareness Campaign. Members developed a curriculum for all health classes and presented it to the Delaware Department of Education for review. It also reviewed topics such as Medicaid enrollment for dentists, improving access to care in underserved areas, and expanding the dental residency program downstate.

DHSS Division of Management Services (DMS). Provides human resources, budget development, and evaluation services to other DHSS divisions. DMS also houses the Birth to Three Office, which provides administration for Part C. Birth to Three is a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families. DMS staff provides overall management for the system and ensures compliance with the federal requirements of the Individuals with Disabilities Education Improvement Act of 2004, which provides funding to help support the system.

Children and their families receive early intervention supports and services by Child Development Watch within the Division of Public Health, with staff drawn from DPH and DDDS. Major external partners, through interagency agreements and contracts, are Department of Education; Department of Services for Children, Youth and Their Families; Christiana Care Health Services, Inc.; Alfred I. duPont Hospital for Children; and community providers.

DHSS Division for the Visually Impaired (DVI). The DPH Child Development Watch works with DVI to provide service coordination for children with visual impairments or who blind.

DHSS Office of Emergency Medical Services. Delaware first received EMSC grant funding in 1997 and the program officially began with the hiring of a program coordinator in 1998. Some examples of cutting-edge work underway with support from the EMSC program are projects to: provide specific education and equipment for all levels of pediatric emergency care providers; ensure that Delaware EMS protocols are developed to meet the needs of children; to develop emergency care and disaster education and training programs for child care agencies; and ensure that all state trauma/disaster plans address pediatric needs. More detailed information on Emergency Services for Children is outlined in Section VI.

Department of Services for Children, Youth, and Their Families (DSCYF). Established in 1983 by the General Assembly of the State of Delaware and collaborates closely with the DPH. Its primary responsibility is to provide and manage a range of services for children who have experienced abandonment, abuse, adjudication, mental illness, neglect, or substance abuse. Its

services include prevention, early intervention, assessment, treatment, permanency, and after care. The KidsDepartment employs approximately 1,200 staff at 31 locations, who serve over 8,000 children on any given day. Among the workforce are 52 Family Crisis Therapists (FCTs), who work in elementary schools throughout the state. Additionally, the Department provides licenses to nearly 2,200 daycare operations, which provide services for more than 49,000 children in Delaware.

Division of Family Services (DFS). Services provided are child oriented and family focused. The Foster Care staff work with Delaware's foster families to protect and nurture children; meet the children's developmental needs and address developmental delays; support relationships between children and their families; promote permanency planning leading to reunification with the child's family or other safe nurturing relationships intended to last a lifetime. The Office of Child Care Licensing strives for a high standard of care and ensures safe environments for children by providing guidance, training and support to many day care providers throughout the state, and investigating complaints concerning day care facilities. The Division's Office of Children's Services also assesses families with problems and provides them with supportive services to empower them to protect and nurture their children.

Division of Youth Rehabilitative Services (DYRS). Provides services to youth who have been adjudicated delinquent and ordered by the court system to receive rehabilitative services. DYRS works closely with the community and DPH through the Community Advisory Board, DYRS serves approximately 5,000 youth per year, ranging from probation to secure care incarceration. In Delaware, there are five secure care facilities that provide secure detention for youth and 24-hour custodial care and treatment for incarcerated, adjudicated youth. Secure care also provides appropriate education, treatment, counseling, recreation, vocational training, medical care, and family focused case management for youth in secure residential facilities. Furthermore, the DYRS Community Services unit provides probation and aftercare services to approximately 3,000 youth per year, in addition to overseeing 47 contracts with providers offering residential and nonresidential programs and services. Community Services operate to ensure that the risks to the public is minimized, youth are served in the least restrictive environment appropriate for their needs, and the families of the youth are strengthened through Community Services intervention.

American Academy of Pediatrics (AAP). The DPH has established close partnerships with health professional programs including the Delaware Chapter of the American Academy of pediatrics (AAP). The AAP, Medicaid, and the Family Health Section have participated on the vaccine committee, EPSDT implementation committee, and lead poisoning prevention committee. The AAP has also been involved in the injury prevention efforts of DPH, Part C planning, the medical home project, and breastfeeding promotion as well as on a scientific committee addressing the problem of infant mortality.

The Delaware Coordinating Council for Children with Disabilities (DCCCD or CCCD) has been active as an advisory committee for the CYSHCN program. This has increased both the formal and informal interagency collaboration statewide.

The Autism Surveillance and Registration, or an Autism Registry. Enables the DHSS and DPH to collect basic descriptive information on the individuals with autism, to track changes in prevalence over time, to inform the planning of service delivery to children with autism and their families, and to facilitate autism research. The purpose of the Autism Registry is to provide an accurate and continuing source of data concerning autism to provide information to Public Health officials. The Autism Registry will gather data to assist with: prevalence estimation, cluster investigation, risk factor identification, and outcome assessment.

Section 619/Special Education for Ages 3-5 Coordinators: This program provides free appropriate public education (FAPE) for children, ages 3 through 5 years, with disabilities in Delaware.

State Interagency Coordinating Council (ICC). The ICC advises appropriate agencies on the

unmet needs in early childhood special education and early intervention programs for children with disabilities, assists in the development and implementation of policies that constitute a statewide system, and assists all appropriate agencies in achieving full participation, coordination, and cooperation for implementation of a statewide system.

CYSHCN Survey. To better understand the CYSHCN population and the needs and challenges they face, the CDC conducted a telephonic survey in 2005--2006 titled the National Survey of Children with Special Health Care Needs. The results did provide valuable information for Delaware but due to a small sample size and lack of a diverse sample, the results were not representative of CYSHCN in Delaware. The DPH is conducting an additional mixed method survey in 2010 to try to capture a broader and more representative sample. The CDC is aware of the survey and offered assistance if needed.

Transition of Care for CYSHCN. A major challenge to CYSHCN and their families is the transition into adult care. Collaborations exist between family members, physicians, therapists, educators, and service providers who belong to DCCCD, the Office of Children with Special Health Care Needs, DPH, and the Alfred I. duPont Hospital for Children Transition Committee to understand the struggles to navigate and transition to adult care for young adults with chronic conditions and disabilities. The Delaware Transition Initiative at the Alfred I. duPont Hospital for Children established the Transition Survey Project to further explore young adults and families issues when they transition from specialized pediatric health care systems into community-based adult health care systems. The major takeaways from the survey demonstrated the significant lack of specialized providers for young adults, the lack of assistance and education families and the youth receive about the process, and the lack of communication between current and future providers. The CYSHCN survey the DPH is conducting in 2010 is also addressing the transition issue and hopes to make positive changes in the near future.

Family Support Initiative (FSI): The FSI, or umbrella organization concept, was developed by the MCH Director in 2008 after a site visit with the Rhode Island MCH program. Rhode Island had a successful model for CYSHCN and family support services where an umbrella organization (Rhode Island Parent Information Network) helped convene and strengthen resources and services through a network of CYSHCN organizations. In Delaware, the goal is that the umbrella organization convenes partner organizations (either formal organizations or parent groups) whose work focuses on meeting the needs of CYSHCN. Partner organizations provide input and strategic guidance as part of an Advisory Council to the umbrella organization. CYSHCN are strongly represented as part of the organization's governance structure. The umbrella organization has the "bird's eye view" and works with partner organizations to decrease duplication in services, increase access to services and address unmet needs to ensure the system of CYSHCN family support is meeting the needs of families.

F. Health Systems Capacity Indicators

Introduction

In FY 2007, the Division of Public Health implemented a Center for Excellence in Maternal and Child Health Epidemiology. The primary responsibility of this unit is to conduct and collaborate on research initiatives related to Maternal and Child Health with an emphasis on Infant Mortality and Poor Birth Outcomes. The Center works closely with the State Vital Statistics Office and Medicaid to study and monitor measures related to maternal and child health and associated health systems capacity indicators. Center staff provides expertise on research, data and statistics and share information internally with other Title V staff, as well as with numerous other partners in the Division, State and larger community. The Center's name was changed in 2009 to the Center for Family Health Research and Epidemiology. During the past year the Center has contracted with APS Healthcare to provide research and consulting on epidemiological studies related to maternal and child health. In addition to the Center, the state's State Systems Development Initiative (SSDI) provides resources for ad hoc reports involving multiple databases (Vital Statistics, PRAMS, Newborn Screening, etc.).

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	69.1	63.2	61.3	61.3	61.3
Numerator	378	362	353	353	353
Denominator	54668	57303	57585	57585	57585
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Asthma is a major public health problem of increasing concern in the United States. From 1980 to 1996, asthma prevalence among children increased by an average of 4.3% per year, from 3.6% to 6.2%. Low-income populations, minorities, and children living in inner cities experience disproportionately higher morbidity and mortality due to asthma (CDC, 2009).

While the number of adults with asthma is greater than the number of children with asthma, the asthma rate is rising more rapidly in preschool-aged children than in any other group. Asthma is the leading serious chronic illness of children in the U.S. In 2006, an estimated 6.8 million children under age 18 (almost 1.2 million under age 5) currently had asthma, 4.1 million of which had an asthma attack, and many others have "hidden" or undiagnosed asthma. In 2006, the highest current prevalence rate was seen in those 5-17 years of age (106.3 per 1,000 population), with rates decreasing with age. Overall, the rate in those under 18 (92.8 per 1,000) was much greater than those over 18 (72.4 per 1,000) (American Lung Association, n.d.).

National indicators for asthma include the Healthy People 2010 leading health indicator: 24 Promote respiratory health through better prevention, detection, treatment and education efforts. Prevention and care of diseases caused by an unhealthy environment is a Healthy Delaware 2010 goal.

The following programs exist in Delaware to ensure a healthier environment.

- The Department of Natural Resources and Environmental Control (DNREC) monitors six air pollutants, and produces an Air Quality Index (AQI), which is available on the DNREC website. The report shows the number of days the AQI is rated unhealthy for sensitive individuals.
- DNREC also monitors pollutants called Fine Particulate Matter, which are dangerous because

they can penetrate more deeply into the lungs than large particles. Delaware has not been able to comply with the National Ambient Air Quality Standards for Fine Particulate Matter, because New Castle County's yearly average pollution level is greater than the standard.

- Eight years of evidence-based, comprehensive tobacco prevention and education programs in the state have resulted in significant reductions in cigarette smoking in our state. The state's strong Clean Indoor Act is also protecting people with asthma from exposure to second-hand tobacco smoke in public places.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	88.1	86.4	89.0	88.9	88.9
Numerator	5421	5761	6143	5973	5973
Denominator	6154	6666	6899	6719	6719
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

2009 Annual EPSDT Participation Report

Notes - 2009

2009 Annual EPSDT Participation Report

Notes - 2008

2008 CMS EPSDT Annual Report. Retrieved on 6/17/10 from http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp#TopOfPage

Narrative:

Developmental delay refers to when a child's development lags behind established normal ranges for his or her age. Sometimes the term is used for mental retardation, which is not a delay in development but rather a permanent limitation. If most children crawl by eight months of age and walk by the middle of the second year, then a child five or six months behind schedule in reaching these milestones may be classified as developmentally delayed regarding mobility. Some children have global delays, which means they lag in all developmental areas (Developmental Delay, n.d.). Developmental Delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental Delays can exist in one or more of the following: cognitive skills; communication; social skills and emotional skills functioning; behavior; and fine and gross motor skills. According to the 2005/2006 National Children with Special Health Care Needs Survey 5% of children/youth (0-17 years) have special needs that include ongoing emotional, behavioral or developmental issues in Delaware. Nationally, 4% of children/youth have special needs that include ongoing emotional, behavioral or developmental issues. In 2006, 908 children aged 0-3 years received early intervention services

in accordance with Part C in Delaware. Fifty nine percent (59%) were white, 28% were black, 11% were Hispanic, 2% were asian or pacific islander and .1% were american Indian or alaska native. Children 2-3 years of age (> 24 to < 36 months) accounted for 55% of the children receiving services while 12% were birth to 1 year of age (0 to < 12 months) and 32% were 1 to 2 years of age (> 12 to < 24 months). Sixty two percent (62%) of children receiving services were female and 38% were male (Birth to 3 Annual Report, 2007).

Nationally, 3-7% of children suffer from Attention Deficit Hyperactivity Disorder (ADHD). According to the 2005/2006 National CSHCN Survey 29.8% of children with special health care needs have been diagnosed with ADHD nationally. In Delaware, 39.2% of children with special healthcare needs were diagnosed with ADHD.

National measures regarding developmental delay issues include the Healthy People 2010 leading health indicators: 16-14, Reduce the occurrence of developmental disabilities. Programs in Delaware include:

- Birth to Three is a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services and supports for infants and toddlers with disabilities and developmental delays and their families.
- Child Development Watch is the statewide early intervention program for children ages birth to 3. The program's mission is to enhance the development of infants and toddlers with disabilities or developmental delays and to enhance the capacity of their families to meet the needs of their young children.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator					
Numerator	0	0	0	0	0
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Final

Notes - 2010

All infants are eligible for Medicaid and therefore do not get SCHIP.

Notes - 2009

All infants are eligible for Medicaid and therefore do not get SCHIP.

Notes - 2008

All infants are eligible for Medicaid and therefore do not get SCHIP.

Narrative:

Children less than one year of age are not enrolled in SCHIP in Delaware. Infants are served by Medicaid.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	71.3	68.4	74.8	74.8	74.8
Numerator	8450	8256	8982	8982	8982
Denominator	11857	12069	12016	12016	12016
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

After increasing steadily through the 1990s and leveling off from 1998-2002 to 2001-2005, first trimester prenatal care attainment in Delaware decreased for the third consecutive time period, from 84 percent to 78 percent in 2003-2007. Since 2001-2005, each of the three counties and Wilmington experienced decreases in the percentage of mothers receiving prenatal care attainment in the first trimester, though in Sussex county the decline had begun in 1998-2002. In 2003-2007, prenatal care attainment in the first trimester ranged from 63.4 percent in Sussex county to 84.5 percent in New Castle.

New Castle county had the highest rates of women receiving prenatal care in the first trimester, regardless of race (84.5%); Not including Wilmington with the balance of New Castle County produced similar results (85.9%). With the exception of Sussex county, black mothers and mothers of Hispanic origin received similar percentages of prenatal care in the first trimester (range 60.1% to 78.7%). Not only did Sussex County have the lowest percentage of mothers receiving prenatal care in the first trimester (63.4%), but it also had the greatest difference between Hispanic mothers and white and black mothers (27.1% vs. 64.2%, respectively).

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	93.8	94.2	94.3	91.2	96.8
Numerator	81133	89704	94332	96861	107430
Denominator	86503	95253	100015	106259	111009

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Division of Medicaid and Medical Assistance

Narrative:

The percent of potentially Medicaid-eligible children who have received a service paid by Delaware's Medicaid Program is reported in Table 7A. Due to economic conditions in 2009, the number of clients receiving a service has increased. The overall percentage, though reported as a decrease, may not accurately reflect the situation. The methodology to produce the denominator has changed from year-to-year over the past several years. The vast majority of Delaware's Medicaid Clients are enrolled in MCOs, however a portion still receive fee for service reimbursement or pharmacy-only reimbursement. These populations have not been included in some previous year's reporting.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	45.4	33.4	49.8	54.4	54.4
Numerator	7472	5684	8880	10234	10234
Denominator	16474	16996	17817	18828	18828
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

2009 EPSDT Participation Report

Notes - 2009

2009 EPSDT Participation Report

Notes - 2008

2008 Annual EPSDT Participation Report.

Narrative:

The Delaware Healthy Children Program is low-cost health insurance coverage for children in low-income families, costing between \$10 and \$25 a month regardless of the size of the family. It covers doctor visits, hospital stays, prescriptions, dental, glasses and more.

DHCP, which is also called the State Children's Health Insurance Program or SCHIP, is run by Delaware Health and Social Services, but the Insurance Commissioner's Office is currently working to help enroll more children in the DHCP.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	3334	2927	3486	3577	3577
Denominator	3334	2927	3486	3577	3577
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

2009 State SSI Beneficiaries Aged 17 and Under. www.statehealthfacts.org

Notes - 2009

2009 State SSI Beneficiaries Aged 17 and Under. www.statehealthfacts.org

Notes - 2008

SSI Annual Statistical Report, 2008

Narrative:

Delaware's Family 2 Family Program (F2F) partnered with the Healthy Delawareans with Disabilities Project and Al DuPont Hospital's transition coordinator on a series of workshops for parents and youth on healthy transitions. F2F trained the parents and the transition coordinator trained the youth simultaneously. F2F trained the parents of the transition timeline and what should be done to prepare the youth, from switching doctors, to guardianship issues and rights and special needs trusts. The trainings also explained the changes in Medicaid and SSI eligibility. Parents were provided with community resources and agencies to explore opportunities after their child leaves the school system. This training is being repeated and it will be held statewide.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	9.7	7.4	8.5

Notes - 2012

2008 Delaware Vital Statistics Data

Narrative:

A recent evaluation of the Healthy Women, Healthy Babies Program (formerly Family Practice Team Model) revealed that out of 1,693 infant deliveries studied since the program's inception in 2008, 26 were very low birth weight, 124 were low birth weight (9% of births). This rate of low birth weight infants is lower than the statewide rate of low birthweight infants receiving Medicaid coverage.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	payment source from birth certificate	10.3	6.8	8.4

Notes - 2012

2008 Delaware Vital Statistics Data

Narrative:

Nationally, the infant mortality rate has remained level since 2000 at 6.86 deaths per 1,000 live births (2000-2005 average). As the rate has remained relatively stable, the disparity ratio has also been consistently high. Non-Hispanic black women are almost two and a half times more likely to experience an infant death compared with non-Hispanic white women (disparity ratio = 2.4).

In Delaware, the infant mortality rate continued to increase in the early 2000s to level at 8.8 deaths per 1,000 live births in the 2002-2006 time period. Like the U.S. disparity ratio, Delaware's infant mortality disparity ratio has remained consistently high with black women two and a half times more likely to experience an infant death compared with white women (disparity ratio = 2.5; 2002-2006). Additionally, both the infant mortality rate and disparity ratios vary by county. Kent County has the highest infant mortality rate, while Sussex County has the highest disparity ratio.

Intervention programs in Delaware specifically aimed at reducing infant mortality include the Healthy Women, Healthy Babies program. The program, initiated in 2007, focuses on women who are members of minority groups, reside in zip codes with high numbers of infant deaths, are underinsured or uninsured, have experienced a previous poor birth outcome such as low birth weight or premature delivery, fetal death, stillbirth, or infant death, and who are coping with chronic diseases. Also, the Smart Start program is a prenatal program that traditionally has focused on prenatal care for underserved populations throughout the state.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	61.2	83.3	72.7

Notes - 2012

2008 Delaware Vital Statistics Data

Narrative:

The Family Practice Team Model and the Preconception Care Program are now integrated into the Healthy Women, Healthy Babies Program. Other programs with a strong prenatal focus in the State include the Nurse Family Partnership through Children and Families First and Smart Start through the Division of Public Health.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	65.2	83.9	74.8

Notes - 2012

2008 Delaware Vital Statistics Data

Narrative:

The Family Practice Team Model and the Preconception Care Program are now integrated into the Healthy Women, Healthy Babies Program. Other programs with a strong prenatal focus in the State include the Nurse Family Partnership through Children and Families First and Smart Start through the Division of Public Health.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2010	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)		

Notes - 2012

Infants are not eligible. Infants receive Medicaid.

Narrative:

The percent of poverty level for eligibility in the State's Medicaid program for infants are reported in Table 6A. In Delaware the SCHIP program eligibility begins at 1 year of age. Infants are served through Medicaid.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2010	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2010	200

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for children are reported in Table 6B.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2010	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP

Pregnant Women		
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Notes - 2012

Pregant women receive Medicaid.

Narrative:

The percent of poverty level for eligibility in the State's Medicaid program for pregnant women is reported in Table 6C. Pregnant women do not receive SCHIP.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2012

Narrative:

The Delaware SSDI program has been able to accomplish several projects in previous years. The SSDI Director worked vigorously on building a relationship with the Health Statistics Center who houses the birth cohort file, birth certificates, infant death records and fetal death records. The Health Statistics Center now sends the SSDI program the birth cohort file (linked birth certificates and infant death file) once the data has been validated and cleaned. The 1989-2007 birth cohort file was received this past May which is the most current file available.

The SSDI program coordinated efforts with the Center for Family Health Research and Epidemiology to create the Registry for Improved Birth Outcomes. The Registry is a list of all women who had a poor birth outcome (premature, low birth weight or infant death). The Registry was created using 1989-2004, 1989-2005 and the most recent data 1989-2006. It contains information on the risks that women with more than one poor outcome face in Delaware. The SSDI Director provides an analysis of the Registry annually and the analysis is included in the annual report for infant mortality. The annual report for infant mortality is disseminated to state and national partners via meetings, conferences and websites.

After establishing a working group on the Birth Defects Registry, the program transitioned from a passive surveillance to an active surveillance system. A Request for Proposal (RFP) was released and a vendor was selected to conduct case abstraction. The MCH Director worked with the Newborn Screening Medical Director to create an active surveillance protocol and case abstraction form. The protocol was based on the National Birth Defects Prevention recommendations and recommendations from the Texas Birth Defects Surveillance program.

The program awarded a contract to provide services for active surveillance for the Birth Defects Registry. The contract has been in place for about two years and a great deal of work has been done to ensure we are identifying and recording as many birth defects as possible. The contractor has developed several processes to ensure the integrity of the data is not jeopardized. Relationships with every medical records department of the birthing facilities and the children's hospital in the state have been developed. The medical records department sends information on every child under the age of 5 who has an ICD-9 code identifying a birth defect on their chart. A memorandum of understanding was established with the Fetal Infant Monitoring Review (FIMR) board to receive data, as well. The contractor has finished with 2007 and is working on 2008 data now. Data analysis of birth defects surveillance system will take place and will be included in the annual infant mortality report.

The Family Health and Systems Management Section developed a new module for the Healthy Women/Healthy Babies (HWHB) program. The additional module was added to our current Case Management System for the Newborn Metabolic, Hearing and Birth Defects Registry programs. The HWHB program provides preconception, prenatal, postpartum and interconception services. Services are targeted to women who are African American, whose most recent pregnancy had a poor birth outcome (premature

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2012

Narrative:

In 2009, the adult smoking rate reached an all-time low of 17.8% and the high school smoking rate plunged to its lowest rate of 17.3%. More than 3,500 adult Delawareans enrolled in cessation counseling services: 2,346 chose Quitline (telephone); 1,773 chose face-to-face counseling; and 1,211 enrolled in Delaware Quitnet (web-based). The Tobacco Prevention Program awarded 31 community grants that will engage more than 11,500 youth and 6,200 adults in tobacco prevention activities.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In the 2010 MCH Block Grant application, Delaware revisited its State Performance Measures based on the early stages of the Five Year Needs Assessment process. With this application, which incorporates the seven original performance measures reported in July 2010, three new state performance measures have been added. Two of these performance measures were included in revisions to the 2010 MCH Application submitted in September 2009 as result of recommendations from the Federal-State Partnership Review. One of the measures is related to developmental disabilities and the second tracks benchmarks completed for the implementation of the statewide Family Support Initiative for Children with Special Health Care Needs.

Since September, the State has recognized the need for a broad measure to gauge progress on issues related to Children with Special Health Care Needs. It was decided to track disparities among Children with Special Needs along a number of domains. Based on findings from the 2007 National Survey on Children's Health (NSCH), a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

According to the 2007 NSCH:

Disparities in Child Health Indicators

- **General Health.** Among those aged 0-17 years in Delaware, 71% (CI 65.1-76.9) of Children with Special Health Care Needs (CSHCN) were reported to be in overall excellent or very good health. This compared to 88.7% (CI 86.4-91.0) of non-CSHCN.
- **Oral Health.** Among those aged 1-17 years in Delaware, 64.1% (CI 57.8-70.4) of CSHCN were reported to have teeth that were in excellent or very good condition. This compared to 75.2% (CI 72.0-78.4) of non-CSHCN. In this same age range, although not statistically significant, 15.2% of CSHCN were reported to have two or more oral health problems in the past six months. This compared to 8.1% of non-CSHCN.

Disparities in Emotional and Mental Health

- **Parental Concern.** Among those aged 4 months to 5 years in Delaware, 58% (CI 42.3-73.7) of parents of CSHCN reported concern over their child's physical, behavioral or social development. This compared to 36.4% (CI 30.9-41.9) of parents of non-CSHCN.
- **At-Risk Children.** Among those aged 4 months to 5 years in Delaware, 28.5% (CI 11.9-45.1) of CSHCN were reported to be at high risk for developmental, behavioral, or social delay. This compared to 7.2% (CI 4.2-10.3) of non-CSHCN.
- **Social Behaviors.** Among those aged 6 -- 17 years in Delaware, 81.1% (CI 74.6-87.7) of CSHCN were reported to consistently exhibit positive social behaviors. This compared to 94.6% (CI 92.4-96.8) of non-CSHCN. Furthermore, among this same age cohort, 24.8% (CI 17.8-31.8) of CSHCN were reported to often exhibit problematic social behaviors. This compared to 4.5% (CI 2.8-6.3) of non-CSHCN.

Disparities in Health Care Access and Quality

- **Continuous and Coordinated Health Care.** Among those aged 0-17 in Delaware, 48.4% (CI 42.0-54.8) of CSHCN were reported to have a medical home that provided continuous,

coordinated, comprehensive, family-centered and compassionate health care services. This compared to 63.6% (CI 60.3-67.0) of non-CSHCN.

- **Effective Care Coordination.** Among children needing care coordination in the past year, 52.1% (CI 44.6-59.7) of CSHCN were reported to receive effective care coordination. This compared to 79.3 (CI 74.9-83.7) of non-CSHCN.

- **Specialist Care.** Among children who needed specialist care in the past year, 14.2% (8.9-19.5) of CSHCN were reported to have had problems getting specialist care. This compared to 3.9% (CI 2.5-5.2) of non-CSHCN.

Disparities in Family Health

- **Mother's Health.** Among children in Delaware that lived with their mother, 53.9% (CI 47.3-60.4) of mothers of CSHCN were reported to be in very good or excellent general health. This compared to 66.6% (CI 63.2-70) of mothers of non-CSHCN.

- **Mother's Mental/Emotional Health.** Among children in Delaware that lived with their mother, 63.2% (CI 56.6 -- 69.8) of mothers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 75.4% (CI 72.3-78.5) of mothers of non-CSHCN.

- **Fathers Mental/Emotional Health.** Among children in Delaware that lived with their father, 71.4% (CI 64.7-78.2) of fathers of CSHCN were reported to have very good or excellent mental or emotional health. This compared to 82.2 (CI 79.2-85.1) of fathers of non-CSHCN.

B. State Priorities

The States Priorities are as follows:

Infant Mortality

Infant Mortality is a top priority in Delaware since the Infant Mortality Rate (IMR) is consistency higher than the U.S. average. In 2005, the Governor convened an Infant Mortality Task Force (IMTF) to make recommendations for reducing infant deaths in Delaware. The task force put together list of 20 recommendations. The task force developed into the DHMIC. The Consortium united with the DPH to establish infant mortality programs. Of the 20 recommendations, half were implemented over the following three years including targeted services for women during the preconception, prenatal, and postpartum periods. Additionally, research to explore the causes of infant mortality was undertaken through surveys and implementation of state surveillance systems. Through the combined effort of DHMIC and the DPH and support from the Governor's office and the Delaware Legislature, the DHMIC prenatal programs reached 20% of all Delaware pregnancies in 2008. Furthermore, Delaware's IMR decreased for the second consecutive period. From 2002-2006 to 2003-2007, IMR declined 3%, from 8.8 infant deaths per 1000 live births in 2002-2006 to 8.5 in 2003-2007.¹ The rate is still too high especially when at looking at racial disparities. The data show a disparity in infant deaths among Black mothers compared to Caucasian mothers, with the largest disparity evident in Sussex County. At 16.9 deaths per 1,000 live births, the rate for Blacks in Sussex County is over three times as high as the rate for Caucasians, which stands at 5.0 per 1,000.

During the 2003-2007 period, the primary cause of infant death in Delaware was low birth weight and prematurity.¹ The second leading cause of death, however, varied by racial group. For Black non-Hispanic women, sudden infant death syndrome (SIDS) was the second leading cause of death while birth defects were the second leading cause of death among White non-Hispanic women.

Low Birth Weight Infants/Preterm Birth

Infant low birth weight is a major predictor of infant mortality. Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature. Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome.

Delaware has the eighth worst infant low birth weight percentage in the nation.⁷ The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.28% in the 2003-2007 period.¹

Preterm birth is the leading cause of infant mortality and morbidity in the United States. Preterm-related deaths account for more than one-third of all infant deaths, and more infants die from preterm-related causes than any other cause. Proper birth spacing is found to be a factor in preterm birth and a maternal health indicator. Health professionals' consensus is that minimum birth intervals of two years are important for infant, child and maternal health.¹² Interpregnancy intervals (IPIs) of less than 6 or 12 months are associated with an increased risk of preterm birth. A meta-analysis of 67 studies showed IPIs shorter than 6 months were associated with increased risks of preterm birth, low birth weight deliveries, and small-for-gestational age (SGA) infants compared with interpregnancy intervals of 18 to 23 months.

Child/Teen Obesity and Overweight

A child's weight status is determined based on an age- and sex-specific percentile for BMI rather than by the BMI categories used for adults. Classifications of overweight and obesity for children and adolescents are age and sex specific because children's body compositions vary as they age and vary between boys and girls. The definition for being overweight or obese is:

- Overweight is defined as a BMI at or above the 85th percentile and lower than the 95th percentile.
- Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.

The 2007 NSCH data indicated that for children ages 10-17 years nationwide, 32% are overweight (between the 85th and 95th percentile BMI-for-age) or obese (at or above the 95th percentile BMI-for-age).⁵² The 2007 NSCH reported that 35% of male children ages 10-17 years nationwide were overweight or obese compared to 27% of female children ages 10-17 years nationwide.⁵² For NSCH, 33% of children ages 10-17 years in Delaware were overweight or obese in 2007.⁵² According to the 2007 NSCH, 34% of male children ages 10-17 years in Delaware were overweight or obese compared to 32% of female children.⁵²

The link between early childhood and the onset of childhood obesity has been identified as a growing concern in Delaware. In collaboration with the Health Promotion and Disease Prevention Section, the Title V MCH Program provided start-up funds for the development of a childhood obesity curriculum, "Healthy Habits - Healthy Start." The goal of "Healthy Habits, Healthy Start" is to train childcare providers in Delaware in how to use tools to increase physical activity and healthy eating of the children in their care while keeping in mind current childcare regulations. The tools in this training are the Sesame Street Healthy Habits for Life Resource Kit and Nemours Best Practices for Healthy Eating: A Guide to Help Children Grow Up Healthy. Under this project, the University of Delaware's Cooperative Extension, with input from Nemours Health and Prevention Services developed a curriculum consisting of 2 three hour sessions. Trainings commenced in January 2010 and have been offered on a monthly basis.

Obesity Among Women of Childbearing Age

Data from the National Health and Nutrition Examination Survey indicate that the prevalence of obesity among women has slightly increased over time from 33% in 2003-2004 to 35% in 2005-2006. The National Center for Health Statistics indicates that in 2006, 62% of all women over

age 20 were overweight. Black non-Hispanic women had the highest prevalence of obesity and overweight (80%), followed by Hispanic women (73%) and White non-Hispanic women (58%). The total cost of obesity and overweight in the U.S. in 2001 was \$117 billion, \$61 billion in direct cost, and \$56 billion in indirect costs. Delaware BRFSS data indicate that 63% of residents between ages 18 and 64 are overweight or obese. Twenty-three percent (23%) of adult women in Delaware are considered obese.

Specific demographic characteristics are associated with obesity and overweight such as increasing age, race, childhood poverty, less education, and marital status. Health conditions causing obesity and overweight include food cravings, hormone changes, pregnancy, depression or anxiety, physical inactivity, stress, stressful life events, personality disorders, lifetime tobacco use, self-rated health, and body image. Weight gain among woman was more likely to contribute to a poor health self-rating compared with women who do not gain weight. Chronic conditions associated with obesity and overweight include hypertension, diabetes, and other metabolic disorders.

Unintentional Injury and Mortality among Children and Youth

The term covers a wide variety of incidents that occur from intentional and unintentional events which result in injury or death. Injuries can result from such things as motor vehicle accidents, falls, choking, firearms, fires, poisoning, athletic events, to name a few. Injuries may be severe enough to cause death. Once children reach the age of five years, unintentional injuries are the biggest threat to their survival. Risk for injury death varied by race. Injury death rates were highest for American Indian and Alaska Natives and were lowest for Asian or Pacific Islanders. Overall death rates for Whites and Blacks were approximately the same.

In Delaware in the 2003-2007 period, unintentional injuries comprised 18.43% of the deaths for children between ages 1-19 years.¹ Moreover, in the 2003-2007 period, unintentional injuries were the leading cause of mortality representing 29.3% of deaths (17 of 58 deaths) for ages 1-4 years, 26.1% of deaths (18 of 69 deaths) for ages 5-14 years, and 55.3% of deaths (105 of 190 deaths) for ages 15-19 years.

Teen Smoking

Teen tobacco use includes smoking (cigarettes, cigars) and the use of smokeless tobacco. Most adults addicted to tobacco in the United States started smoking during adolescence, and without intervention, most current teenage smokers can be expected to continue smoking into adulthood.

The 2009 Delaware YRBS reported that 47.7% of students tried cigarette smoking at one point in their life, 19.0% smoked cigarettes on one or more of the past 30 days, 11.9% smoked at least one cigarette every day for 30 days, and 6.8% used chewing tobacco, snuff, or dip on one or more of the past 30 days.⁵³ These results parallel nationwide rates (50.3% of students nationwide tried cigarette smoking at one point in their life, 20.0% smoked cigarettes on one or more of the past 30 days, and 7.9% used chewing tobacco, snuff, or dip on one or more of the past 30 days using 2007 U.S. YRBS data).⁵⁵ Overall, 23.2% of Delaware students have used tobacco in some manner at least one in the past 30 days.⁵³ In addition, 13.7% (13.8% of males and 13.2% of females) had smoked a whole cigarette for the first time before age 13 years.⁵³ Among students who reported current cigarette use, 47.4% (43.8% of males and 51.4% of females) tried to quit smoking cigarettes during the past 12 months.⁵³

Family Support of Children and Youth with Special Health Care Needs

Family support of children and youth with special health care needs (CYSHCN) is a multi-faceted approach to ensure parents, siblings and extended family have the resources, information, social support through informed networks and emotional support to care for a child with special needs. Family support must be family-centered -- it must meet them where they are and provide what they need in a culturally and linguistically appropriate manner. Since it is a diverse service and a one size fits all approach will fail, DPH MCH program has undertaken a year long stakeholder-led initiative to determine the needs and approach to better meet the diverse support

needs of families. The result is the development of an umbrella organization, called the Family Support Initiative, which has been described extensively in other sections of the narrative.

Developmental Delay

Developmental delays differ from other types of learning disabilities in that they may improve with intervention and may eventually disappear. For that reason, it is important to be aware of early signs of a problem. Developmental delays can exist in one or more of the following: behavior; cognitive skills; communication; emotional skills; fine and gross motor skills; and social skills.

Disparities among Families of Children and Youth with Special Health Care Needs

Disparities among families with CYSHCN are becoming increasingly evident every year. Research shows that a number of key disparities have been identified for Children with Special Health Care Needs (CSHCN) when compared to their peers without special needs. These disparities are most pronounced in four key areas: Child Health Indicators; Emotional and Mental Health Indicators; Health Care Access and Quality Indicators; and Family Health Indicators.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	22	35	33	48	60
Denominator	22	35	33	48	60
Data Source			Newborn Screening Data	Newborn Screening Data	Newborn Screening
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

The view only web-based module for the Newborn Screening Data System was piloted at several pediatric sites throughout the state during 2010. The module was taken to scale statewide.

The Newborn Screening Program's Advisory Board recommended the addition of Severe

Combined Immunodeficiency Disease (SCID) to the core panel of conditions screened for through Delaware's Newborn Metabolic Screening Program. The addition of this condition will make Delaware's core panel of conditions inclusive of all 29 conditions recommended by the federal Department of Health and Human Services as recently announced by Secretary Sebelius.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening Program	X	X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A main focus of the Newborn Metabolic Screening during 2011 was planning for the addition of Severe Combined Immunodeficiency Disease (SCID) to the core panel of conditions screened for through Delaware's Newborn Metabolic Screening Program.

A new MSMS Machine was purchased for the Delaware Public Health Lab. The machine replaces existing equipment that will be used as a back-up in the future.

The program also continued to work on remote data entry in concert with the Newborn Hearing Screening Program.

It is important to note that the program continues to operate at staffing levels below capacity.

Surveillance System for Active Birth Defects. The State Systems Development Initiative program coordinated efforts with the Center for Family Health Research and Epidemiology to create the Registry for Improved Birth Outcomes. The Registry is a list of all women who had a poor birth outcome (premature, low birth weight or infant death). The Registry was created using 1989-2004, 1989-2005 and the most recent data, 1989-2006. After establishing a working group on the Birth Defects Registry, the Newborn Screening (Metabolic) Program, Newborn Hearing and Birth Defects Registry transitioned from a passive to an active surveillance system. The registry inputted 2007 data over the last year and is currently working on 2008 data.

c. Plan for the Coming Year

In 2012, the program will continue to implement SCID screening and investigate the feasibility of screening for congenital cardiac defects, as warranted.

The program will also initiate DNA testing for Cystic Fibrosis.

Once SRV (Secure Remote Viewer) is completely implement and providers are completely trained, the program will eliminate mailing test results to providers thus realizing a cost savings and improving turn-around time.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	11893					
Reporting Year:	2010					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11893	100.0	5	2	2	100.0
Congenital Hypothyroidism (Classical)	11893	100.0	6	6	6	100.0
Galactosemia (Classical)	11893	100.0	46	0	0	
Sickle Cell Disease	11893	100.0	7	6	6	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	65	65	65	65	65
Annual Indicator	56.9	61.1	61.1	61.1	61.1
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer					

than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	2012	2013	2014	2015
Annual Performance Objective	65	65	65	65	

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

During 2010, the Delaware Title V Program increased parent leadership and increased provider willingness and skill in engaging families in decision-making. Delaware continued to rely on the CDC CYSHCN survey to gauge efforts to increase engagement and satisfaction with that engagement. In 2010, Delaware focused on the parent leadership. Delaware invested approximately \$50,000 in F2F for federal FYs 09 and 10 which served to help leverage \$95,700 of HRSA funding in FY09. Family to Family was tasked with increasing parent leadership in CYSHCN activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening Program	X	X	X	
2. Child Development Watch	X	X	X	
3. Oral Health Program	X	X		
4. Primary Care and Physical Therapy, Occupational Therapy and Speech	X	X		
5. Respite Care	X	X		
6. Office of Children with Special Health Care Needs				X
7. Autism Registry				X
8. Birth to Three Early Intervention Coordinator, State Interagency Coordinating Council, Delaware Coordinating Council for Children with Disabilities				X
9. CSHCN Survey				X
10. Family Support Initiative				X

b. Current Activities

The Family SHADE (formerly known as Family Support Initiative) held a statewide Summit Meeting in October, 2010. Over 50 community organizations, agencies and family members came together to begin a dialog on how to improve service and reduce fragmentation for families of CYSHCN. Several brainstorming activities resulted in strategies that could be accomplished by using the umbrella organization framework. One element that was repeated over and over by

Summit attendees was the need for parents to have a consistent voice that could help to guide the service that they receive. One of strategies suggested was the formation of a Parent Advisory Group using an online methodology. The FSI Advisory Board then took this strategy and recommended Families Know Best (FKB). The tenants that guide FBK and its integration into the community are: Parents have the most complete understanding of their child's physical, developmental and social needs; Parents understand their child's needs in the context of the family's situation, culture and community; Parents are the only adults who have been and will continue to be deeply involved throughout the child's life. FKB will allow Family SHADE participating organizations to gain input from families on a routine basis.

c. Plan for the Coming Year

The Bureau plans to press forward with the "umbrella" organization. In order to strengthen community groups serving CYSHCN, DPH led a year-long initiative to develop an "umbrella organization" for family support. The Delaware Division of Public Health partnered with the University of Delaware, Center for Disabilities Studies to administer and coordinate an "umbrella" organization (Family SHADE) that is member-driven, non-profit structure, with the mission to provide strategic guidance, family involvement, coordination of services. The Family SHADE also provides assistance to member organizations in a variety of topics identified by members. A new name for the initiative was selected at its April 2011 Advisory Board Meeting - Family SHADE, for Family Support and Healthcare Alliance DELaware. In addition, Family SHADE will play a critical role through-out the five year life cycle of the MCH Needs Assessment process.

Over the next year, Family SHADE staff will develop a standard web-based and print survey format using Survey Monkey to create an online and print survey consisting of no more than 10 questions per month (or bi-monthly). this survey, which helps drive family input, is coined Families Know Best (FKB). Each month, one question will ask about access to or availability of insurance. Other questions will be submitted by Family SHADE members in order to gauge the current and long term service needs of families. Questions from other Delaware board or councils can be incorporated with the approval of the Family SHADE Advisory Board. Thus, making FKB a statewide resource for all agencies serving CYSHCN throughout the state. All individual responses will remain anonymous. It is critical to the success of the project that families provide input on a regular basis. This helps with continuity of information and reducing the need for continual recruitment. FKB families will receive modest incentives for their continuing participation. Family SHADE staff will analyze and disseminate data received through surveys to organizations and policy makers across the state. Staff will provide follow-up to the FKB families who request it, and inform them of: a) how the information is being used to improve services for CYSHCN; b) how they can stay involved to shape the services and policies that affect their family.

The third prong is to replicate portions of the CDC CYSHCN survey in Delaware using a mixed-methods approach in the intervals between the telephone survey so as to acquire more timely feedback on system performance and family perceptions of services. This survey is expected to be launched in 2012, as soon as the Children and Youth with Special Health Care Needs Director is hired; CDC's lead for the survey has expressed intellectual support for this survey and is available for technical assistance, but has no funds available to invest in the process. This survey will be one of the components of The Bureau's evaluation strategy.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	60	60	50	50	50
Annual Indicator	52.8	48.1	48.1	48.1	48.1
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	2012	2013	2014	2015
Annual Performance Objective	50	50	50	50	

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

During 2010, The Delaware AAP Chapter joined forces with the Family Health Section of the DE Division of Public Health to host a developmental screening symposium on April 28. Delaware's Developmental Comprehensive Screening (DCS) project was funded by Blue Cross Blue Shield of Delaware. This one day event featured key political and medical leaders including the Lt Governor of Delaware and key note speaker, Anne B. Francis, MD, FAAP.

This period's activities have centered on both the letting of a contract to establish the Family SHADE and a strategy to engage providers, including the education system, around the systems building challenge of mounting an autism registry. The Bureau is required by Delaware law to maintain an autism registry. Since its inception in 2005 (an unfunded State mandate), providers

have reported limited data. The Bureau has used this opportunity to coordinate with the American Academy of Pediatrics, specialists, major provider systems, and the Delaware Medical Society to provide updates on autism as well as the requirement by law to report a minimal number of data fields.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. ECCS Program / Health Resources Bureau				X
3. Transition of Care for CSHCN				X
4. Office of Children with Special Health Care Needs				X
5. Autism Registry				X
6. State Interagency Council, Delaware Coordinating Council for Children with Disabilities				X
7. Family Support Initiative				X
8.				
9.				
10.				

b. Current Activities

During 2011, the Family SHADE's goals directly relate to the achievement of this performance measure. The FSI contract began on March 1, 2010. In Delaware, the goal is that the umbrella organization convenes partner organizations (either formal organizations or parent groups) whose work focuses on meeting the needs of CYSHCN. Partner organizations provide input and strategic guidance as part of an Advisory Council.

The contractor facilitating this effort, University of Delaware, Center for Disability Studies (UDS-CDS) formulated a work plan that had these essential elements:

- A group meeting of probable collaborators to launch effort and solicit public input into Needs Assessment
- Conduct a comprehensive environmental scan
- Facilitate a Collaborator's Summit
- Web and print (large print, Braille and audio) information resources
- Communication of emerging issues, opportunities

c. Plan for the Coming Year

Family SHADE goals continue to directly relate to the achievement of this performance measure. CYSHCN are strongly represented as part of the organization's governance structure. The umbrella organization has the "bird's eye view" and works with partner organizations to decrease duplication in services, increase general knowledge about medical homes in primary care pediatric practices through partnerships (DE AAP, Medical Society of Delaware, etc.), increase access to services and address unmet needs to ensure the system of CYSHCN family support is meeting the needs of families.

In response to a new HRSA funding opportunity, Delaware was awarded the State Implementation grant to Improve Services to Children and Youth with Special Health Care Needs in July 2011. Informant interviews have been completed for pre-planning purposes with representatives from the Delaware Chapter of the American Academy of Pediatrics, the Medical Society of Delaware, the Division of Public Health, Nemours Health and Prevention, private health service providers, and the Family to Family Information Center to measure interest and commitment to planning and participation in a Medical Home pilot. These early key stakeholders

possess over two decades of direct or related experience to the medical home model. In several cases, early CYSHCN medical home efforts in Delaware have been funded/supported through external funding sources such as the National American Academy of Pediatrics, the CATCH grant program, and private philanthropy. Over the next year, Title V MCH will identify and engage additional stakeholders including but not limited to public and private sectors, advocacy organizations, education, hospitals and other child service providers, in active dialogue at a mini-summit in the design and oversight of a formal CYSHCN medical home pilot project. 2012 activities proposed include:

- Convene a mini-summit of key stakeholders to exchange information and strategies about increasing physician capacity and enhancing access to medical homes by CYSHCN by June 2012.
- Assemble a team that will be trained in the Learning Collaborative model and use the training to implement the medical home in four medical practices in June 2013.
- Define the role and responsibility of the Learning Collaborative Stakeholder Team relative to medical homes and systems improvement planning and activities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	70	70	65	65	65
Annual Indicator	66.7	63.2	63.2	63.2	63.2
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	2012	2013	2014	2015
Annual Performance Objective	65	65	65	65	

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

An umbrella organization (Family SHADE) was established. In partnership with F2F, a pilot for a family liaison program in one pediatric practice was implemented. The pilot was actualized through the Parent Education Resource Center. The premise was that at the point of diagnosis families would receive guidance and support in accessing all available resources, including insurance. The Parent Education Resource Center (PERC) was one of the primary goals of the Blue Cross Blue Shield Developmental Comprehensive Screening grant. The purpose was to engage parents in the developmental screening process and provide educational and early intervention service resources. The program utilized a Parent Liaison in each of the 4 pilot sites.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN Survey				X
2. State Interagency Council, Delaware Coordinating Council for Children with Disabilities				X
3. Office of Children with Special Health Care Needs				X
4. Family Support Initiative				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2012, the Bureau intends to conduct a survey of families by web and pencil-and-paper that replicates sections of the CDC telephone survey. This will be a lead project of the new Children and Youth with Special Health Care Needs Director, as soon as a candidate is recruited and hired. This mixed-methods survey will provide valuable data in between CDC-released findings. Questions on insurance status to the CYSHCN survey will be included; there is also the ability to ask families to report instances of not being able to acquire care due to lack of insurance -- separate and distinct from question of being unable to acquire care due to lack of providers. The Bureau will also reach out to Department of Insurance and/or Gov. Council on Exceptional Citizens to see how they are tracking/handling complaints from CYSHCN families as a second and possibly third source of data. The Family Support Initiative and its collaborating partners will also be tapped to develop methods of quantifying access to care, such what this performance measure address.

c. Plan for the Coming Year

Supported through HRSA MCHB and Title V, Family to Family (F2F) is a family-led parent empowerment and education program that helps families of CYSHCN navigate the health care

system, access resources and services, and make informed decisions about health care issues. F2F helps families find solutions to issues of health care access, including those created by inadequate private and public insurance. To address these issues, F2F developed the Delawareans with Special Health Care Needs Medicaid Managed Care Panel. The Panel, consisting of representatives of Medicaid and Managed Care Organizations, is convened quarterly to provide an opportunity for families to raise issues of concern regarding insurance coverage directly with those who manage these services. F2F facilitates the dialogue between Medicaid and MCO representatives and parents in an effort to find solutions to issues raised during the call.

Families Know Best, a new project of Family SHADE, will provide a mechanism whereby families can offer regular feedback about the adequacy of their insurance coverage and quickly bring new concerns to the attention of the Special Health Care Needs Medicaid Managed Care Panel. Families Know Best will include specific questions about the adequacy of families' health insurance coverage on regular FKB surveys, and families' responses will be shared with F2F and with the Panel. The Panel's agenda will be responsive to the specific concerns expressed by families participating in the survey and the Panel will have the ability to quickly identify and address new issues as they arise in the community. In addition, families will receive feedback about the concerns they express on the survey and F2F and FSI will be available to provide additional health care-related assistance as needed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	80	80	90	90	90
Annual Indicator	72	88.1	88.1	88.1	88.1
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	2012	2013	2014	2015
Annual Performance Objective	92	92	92	92	

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

The contractor selected as the facilitator for the Family SHADE, University of Delaware - Center for Disability Studies, had as a principal goal, information and referral. Beginning in mid-2010, the umbrella organization canvassed provider and parent support groups in a systematic fashion to collect data needed to form a more comprehensive and effective information and referral system. Family SHADE has engaged the Delaware PIC in a contract that is designed to foster increased linkages and support for building a better I&R system for Delaware. PIC has worked with Hispanic populations to provide information about mental health and other services in Spanish, and this will be an ongoing effort.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Initiative				X
2. Transition of Care for CSHCN				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Family SHADE focuses directly on this performance measure. A comprehensive environmental scan was completed, followed up by a Collaborator's Summit in the Fall of 2010. Following these interactive table discussions, the group provided input regarding the major themes that emerged in the course of their discussions. Feedback included: comments about the need for a more collaborative culture in Delaware; the need to communicate better about programs and the possibility of devising a shared state-wide calendar; the importance of holding trainings together instead of fighting over families; the value of training on best practices concerning the use of social networking; the possibility of having a statewide online family advisory listserv (council) that could be surveyed periodically and provide feedback to the entire Family SHADE membership;

funding barriers to collaboration; and, perhaps most importantly, the need to develop trust. The Summit participants presented a wide variety of ideas and models, but eventually voted to accept as Advisory Council members those Summit participants who volunteered to serve and could make a commitment to working on development of the infrastructure of the organization over the next year. This work included developing mission and vision statements, a strategic plan, bylaws and a draft Memorandum of Understanding for its member organizations.

c. Plan for the Coming Year

Families of CYSHCN acquire information about health care services in fragments from various service providers and conveyors of information. The FSI environmental scan identified that the majority of organizations and providers have difficulty reaching groups that do not have access to computers and email. Over 85% of organizations surveyed send their newsletters and information exclusively via email. This is primarily due to budgetary constraints, but leaves families without internet access with very limited information about programs and services. Additionally, there is no opportunity for families to acquire information from multiple service providers in one location. Through Family SHADE stakeholders, service providers will be invited to participate and showcase their services and how these services can be accessed by families in an annual health and resource event in Delaware's three counties (the first will be held in New Castle county in 2012). This event will be broadly marketed to low income and minority populations through the FSI network of organizations, WIC offices, FQHCs, schools and other agencies.

Family SHADE is also working with Children and Families First, a non-profit organization, to expand their extensive, existing database of services in Delaware to include parameters that specifically address the health care needs of CYSHCN and their families. The database will also be directly available to families via a public online portal available through FSI's website, which is currently under development. In 2006, a print document called Connecting the Dots was developed by the Family to Family Health Information Center staff in collaboration with the University of Delaware's Center for Disabilities Studies. Connecting the Dots provides families with a central location for agency information. As service agencies change locations and contact information, continuous updates are necessary. Through Family SHADE, an electronic and printed "roadmap" (flowchart) that clarifies the relationships between various services, providers, funding streams and eligibility criteria will be developed. The roadmap will also show families the "route" they can take to obtain services when they access the system from various entry points. Plans are underway to develop a linkage between services and the Family SHADE database to create a resource guide for parents that is dynamic and never out of date.

2012 Family SHADE activities that will address this performance measure include:

Developing database with professional access and training opportunities for I&R

Website that lists activities for all organizations for easier access by families and providers.

Families Know Best will provide family input re: needs and services so organizations can refine services.

Developing database and website to provide family friendly access to information.

Development of one-stop I&R phone number to assist parents in finding the service provider with expertise

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010

Annual Performance Objective	20	25	45	45	45
Annual Indicator	5.8	42.4	42.4	42.4	42.4
Numerator					
Denominator					
Data Source			National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006	National Survey of CSHCN, 2005-2006
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	2012	2013	2014	2015
Annual Performance Objective	45	50	50	50	

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

This Federal Performance Measure has to do specifically with the experiences reported by youth during transition regarding their ability to receive the "...services necessary to make transitions..." The Family SHADE has been tasked with working with partners to establish a Transition Plan for the State; it is expected to be developed by the end of the two year contract period. Transition workshops were expanded from New Castle to Kent and Sussex Counties as a part of the Transition Plan Development work. The Family SHADE convened a group of probably collaborators on May 5, 2010 and reviewed the Title V MCH federal and state performance measures. It also launched its overall effort and detailed specifics on a comprehensive environmental scan.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Initiative				X
2. Transition of Care for CSHCN				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau is planning to include questions needed to establish performance on this measure as a part of its mixed-methods replication of portions of the CDC CYSHCN process it will be establishing in the 2012. This assessment activity will help inform the work of the Family SHADE.

Delaware has launched various health care transition activities through different entities over the last few years. The Center for Disabilities Studies (CDS) at the University of Delaware established a transition information website in 2005 in partnership with KenCrest. This online resource for CYSHCN and their families is now located at www.gohdwd.org/health-care/transition-for-young-adults/. In addition, since 2010, CDS has been offering "Healthy Transitions" workshops for youth and young adults with special health care needs and their families to prepare them for their transition from pediatric health care to the adult health care system. "Healthy Transitions" workshops are conducted in partnership with Title V Maternal and Child Health, Delaware's Family to Family Health Information Center and Nemours/Alfred I. duPont Hospital for Children. CDS is also planning a statewide, comprehensive transition plan that will involve all major State and community partners serving youth with special health care need YSHCN.

c. Plan for the Coming Year

In 2012, through the Family Support Initiative/Family SHADE (Family Support and Healthcare Alliance of Delaware), which was initiated and is funded through Delaware's Division of Public Health Maternal Child Health Bureau, a database is under development that will provide information on health care providers in the community who are interested and have expertise in working with patients with complex needs and disabilities. In addition, this database will be a comprehensive resource of supports, services and providers that work with children and youth with special health care needs.

In 2012, Title V, through the Delaware Maternal Child Health Bureau, will continue to provide funding to the Center for Disabilities Studies to conduct its Healthy Transitions workshop series (brochure attached). Healthy Transitions is a 4-part workshop for youth and young adults with disabilities and special health care needs and their family members and/or educators about health care transition preparation. Workshops are offered in schools and to community groups and contain a social component (e.g. dinner; discussion, etc.) and presentation. The four sessions address 1) general transition issues (e.g. starting to identify an adult PCP and specialist(s), making appointments for doctor visits, taking care of one's medication, etc.), 2) insurance issues (e.g. what changes in coverage when you become an adult, how long can you be on your parents' insurance, Medicaid/Medicare, dental care coverage changes, carrying your

own ID card and insurance card, etc.), 3) healthy lifestyles (e.g. healthy nutrition, physical activity and exercise, good oral hygiene, mental health well-being), and 4) healthy relationships (e.g. what does a healthy relationship look like, being assertive, saying "no", feeling good about yourself, etc.). Presentations are conducted by experts on the various topics (e.g. the first session is presented by the Social Worker from Alfred I. duPont Hospital for Children's Division of Transition of Care, the component on healthy nutrition is presented by a certified dietician, etc. etc.). Healthy Transitions is organized and run by the Center for Disabilities Studies but happens in collaboration with many community partners.

Although FSI's environmental scan revealed that various Family SHADE partners have experience working with youth on self-advocacy skills, little is currently offered in a formalized way to help youth develop advocacy and leadership skills. Through Family SHADE partners, a training curriculum for youth will be developed in 2012, specifically addressing the skills and knowledge needed to effectively participate on boards and councils in Delaware that address services for CYSHCN. Through Family SHADE partners, boards and councils will be educated about the importance of including youth and Family SHADE partners will work collaboratively with boards and councils to increase youth presence and involvement.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	90	90	80	82	74
Annual Indicator	76	78.9	80.3	71.8	65.3
Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	70	70	72	72	74

Notes - 2010

2009 National Immunization Data, Q1-Q4 (4:3:1:3:3:1). Confidence Interval +/- 7.1 %. There is not statistically significant difference between rates reported for 2009 and 2010.

Notes - 2009

National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2008. Confidence interval for the estimate is +/- 6.8. Note that the CIs for the 2007-2008 Surveys overlap. There is not statistically significant difference for the 2008-2009 estimates.

Notes - 2008

National Immunization Survey, Selected Vaccination Series by 19-35 Months of Age, Delaware 4:3:1:3:3:1. Estimated Vaccination Coverage, 2007. Confidence interval for the estimate is +/- 5.7.

a. Last Year's Accomplishments

As with every year, the Immunizations Coalition focused on Flu season planning with an efforts of getting all ages vaccinated for seasonal flu. The program coordinated among the providers to try to reach everyone and reduce duplication of effort in serving the public.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Delaware Immunizations Program				X
2. Delaware Division of Public Health and Field Staff	X	X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunizations Program continued working with partners to implement the Immunize Every Size message and promote childhood immunizations toward the goal of achieving 90% up-to-date status by age 2. This includes continuing education with parents and providers. The goal of Immunize Every Size is:

- All children have access to vaccines;
- Healthcare providers are aware of immunization standards of practice;
- The latest recommendations on vaccines are available to providers; and
- Providers and the public have access to up-to-date answers to vaccine questions.

c. Plan for the Coming Year

Continue working with partners to implement the Immunize Every Size message and promote childhood immunizations toward the goal of achieving 90% up-to-date status by age 2. This includes continuing education with parents and providers. The goal of Immunize Every Size is:

- All children have access to vaccines;
- Healthcare providers are aware of immunization standards of practice;
- The latest recommendations on vaccines are available to providers; and
- Providers and the public have access to up-to-date answers to vaccine questions.

The Delaware Immunization Coalition, supported by DPH staff, will have a focus on Flu season planning with an effort this year of increasing influenza vaccination among healthcare workers. Delaware plans on recognizing those providers that make special effort to vaccinate their staff, especially those who provide direct-patient care.

In the coming year, DPH is preparing to roll-out the new Immunization Registry, DelVAX, which will include user-friendly functionality and ultimately, allow for program efficiencies. The new registry will give medical providers access to updated vaccine history for all Delawareans entered into the system. Other enhancements include: Vaccine inventory tracking so that providers can track doses currently on hand, administered to patients, received from the manufacturer, etc. The Immunization Registry system will include reminder/recall functionality that will allow the Immunization Program or providers to produce lists or letters for patients needing vaccinations or to be recalled because of a vaccine issue. In addition, report functionality will allow for the Immunization Program or individual providers to produce reports that are statewide (function reserved for the Immunization Program only) down to the individual provider. These reports will include up-to-date rates, doses of vaccine administered, individual immunization records, the production of geo-maps of various immunization data, etc.

The Immunization Coalition of Delaware plans to hold a 5K Run/ Walk to publicize National Immunization Awareness Month, August, 2011, in DE. Individuals and teams from healthcare sector compete for prizes in the run and immunization awareness is provided through "Facts" signs and educational materials along the route. Nurses are also available post race to talk with individuals about immunization schedules for children and adults.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	27	26	20	20	20
Annual Indicator	22.0	22.0	21.2	21.2	21.2
Numerator	386	387	369	369	369
Denominator	17572	17600	17439	17439	17439
Data Source			Delaware Vital Statistics, 2007	Delaware Vital Statistics, 2007	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	20	20	19.5	19.5	19.5

Notes - 2010

2008 Vital Statistics Data.

Notes - 2009

2008 Delaware Vital Stats Data.

Notes - 2008

2008 data are not available. It is anticipated that 2008 data will become available in early 2011.

a. Last Year's Accomplishments

DPH continued to reassess the reach of the Alliance for Adolescent Pregnancy Prevention (AAPP) programs. Given the limited amount of state funds for teen pregnancy prevention (\$333.0 annually) it is important the funds be utilized to provide evidenced based programs and initiatives that reach those teen most at risk.

In December of 2009, the Division of Public Health was notified that School-Based Wellness Centers (SBWC) were not in compliance with current Medicaid reimbursement regulations. During the course of discussions on Medicaid billing with the various SBWC stakeholders the issue of providing reproductive health services at SBWC was discussed. As a result DPH revisited the delivery of reproductive health services within SBWC. Although STD testing is provided in 75% of all centers, none provide contraception for routine pregnancy prevention. Although this issue is controversial, it merited discussion with each school district to share the community specific epidemiologic data that supports delivery of full reproductive health services at each SBWC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title X Family Planning	X	X		
2. School-Based Wellness Centers	X	X		
3. Infant Mortality (Reproductive Life Plan)		X		
4. Teen Pregnancy Advisory Board				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Delaware's Family Planning Program was recognized as the first in Federal Region III (including Pennsylvania, Maryland, Virginia, West Virginia, and Washington D.C.) to use a set of program performance measures for monitoring and quality assurance. In 2010, the program performed 13 clinic site reviews of eight state clinics and five contracted clinics. DPH's review process used 18 performance measures of the Family Planning Councils of America, Inc. (FPCAI). Clinic performance met or exceeded 11 of the FPCAI benchmarks and averaged within 6% of the remaining seven benchmarks.

Another exciting venture of the Adolescent Health Program is the \$250,000 grant award from the Department of Human Services for the Personal Responsibility Education Program (PREP). PREP funds will develop a state adolescent health plan, provide health education curriculum training to adults, and provide youth education about reducing teen pregnancy, STDs and HIV/AIDS.

In the spirit of collaboration, the Division of Public Health (DPH) partnered with the Alliance for Adolescent Pregnancy Prevention (AAPP) to support the 2010 Teen Summit, which attracted 168 youth and 52 parents and providers. AAPP, in collaboration with DPH, provided continuing support of three adolescent outreach programs: the Wise Guy Program, the Be Proud, Be

Responsible program, and the Project SAFE intervention designed to reduce sexually transmitted diseases in adolescent Latina and African American women between 15 and 24 yrs

c. Plan for the Coming Year

DPH continues to reassess the reach of the Alliance for Adolescent Pregnancy Prevention (AAPP) programs. Given the limited amount of state funds for teen pregnancy prevention (\$333.00 annually) it is important the funds be utilized to provide evidenced based programs and initiatives that reach those teens most at risk.

As a result of the limited amount of State funds the Division of Public Health applied for and was awarded a federal grant under the Department of Health and Social Services, Personal Responsibility Education Program. This grant in the amount of \$250,000.00 will allow DPH to implement and replicate two evidenced-based education programs targeting adolescents through all 19 Delaware public school districts and community-based centers throughout the state. The first health education program Making Proud Choices! will target youth ages 11-13; while the health education program Be Proud! Be Responsible! will target adolescents ages 14 -19. The programs will impact county census divisions with high rates of teen birth rates, STD infection rates and high minority populations.

In addition, utilizing a systems perspective approach, funds from this grant will be utilized to emphasize coordination and collaboration between Delaware State agencies and community organizations serving adolescents. A Sexuality Training Institute will be established to provide technical assistance, materials, and a train the trainer model, in which school teachers, and community volunteers will be trained to facilitate one or both programs to adolescents with fidelity to the model. Program instructors and SBHC will spread awareness of available local family planning and reproductive services and refer adolescents to health care services. Through the collaborative efforts of the Department of Education, DPH, the medical vendors, the 19 school districts and high schools reproductive health will be added to the list of services at the wellness centers provided that there is school board approval and the parent consents to such services for their child beginning July 1, 2011. The DPH defines reproductive health services as they pertain to SBHC as oral contraception and condom distribution only. To date thirteen or 46% the SBHC have indicated they will be implementing reproductive health services.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	35	40	35	35	35
Annual Indicator	34	34	34	34	34
Numerator					
Denominator					
Data Source			Delaware Dental Survey	Delaware Dental Survey	Delaware Dental Sealant Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	35	37	37	39	39

Notes - 2010

The 2009 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

Notes - 2009

The 2009 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

2010 Sealant Stats for the Oral Health Program:

of Children Screened (2nd grade): 30

of Children w/ Caries Presence (Decay): 18

of Total Sealants Placed: 68

#Regular Referral: 15

#Urgent Referral: 5 (urgent is classified when pain or infection present within diagnosis of decay/extraction)

Notes - 2008

The 2008 indicator is based on a 2002 statewide survey of third grade children. More recent estimates are not available at this time.

a. Last Year's Accomplishments

The Delaware Oral health Coalition is focused on reducing the high level of dental disease among the state's children and early prevention and maintenance. Through local and national partnerships, the Coalition is developing an infrastructure to increase awareness about the importance of good oral health and its relationship to good overall health.

The DPH Maternal and Child Health program provides child oral health continuing education to non-dentist professionals who are engaged in health or day care of children and youth. The training is "Open Wide" developed by the National Maternal and Child Oral Health Resource Center (NMCOHRC). DPH MCH (through contract with Health Equity Associates) adapted the on-line program for in-person training. IT was offered in Sussex County to child care providers and received overwhelming response. Additional sessions are scheduled for fall 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Program	X	X	X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

THIS IS A PLACEHOLDER. THIS IS A PLACEHOLDER. THIS IS A PLACEHOLDER.

c. Plan for the Coming Year

Delaware intends to increase the Maternal and Child Health's participation in child dental health issues through collaborative partnerships and established committees and coalitions focused on improving oral health access.

In 2012, the Bureau of Oral Health and Dental plans to offer training to physicians/nurses with enhanced skills and knowledge to provide dental care for infants, toddlers and young children. The bureau will offer training programs to enable physicians to incorporate an oral health evaluation into well-child visits and make referrals to dentists. The goal is to provide targeted training to non-traditional providers, such as primary care physicians, nurses, school nurses and early childhood care providers about the importance of oral health and to expand the frequency of oral health screenings and referrals. In addition to defining the role a provider can play in assessing children's oral health. The Bureau plans to continue these activities with added emphasis on preventing Early Childhood Caries (ECC) by encouraging age-one dental visits to prevent the onset of ECC. The Tooth Troop program will be expanded to community organizations to provide direct outreach to underserved families. In addition, the Seal-A- Smile Program plans to target fifty schools during the next school year using the dental van.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	2.5	2.5	1.7	1.7	1.7
Annual Indicator	1.8	1.8	3.6	3.6	3.6
Numerator	9	9	6	6	6
Denominator	500732	500732	168041	168041	168041
Data Source			Hospital Discharge Data, 2005	Delaware Vital Stats Data	Delaware Vital Stats Data.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	3.4	3.4	3.2	3.2	3.2

Notes - 2010

2008 Delaware Vital Stats Data.

Notes - 2009

2008 Delaware Vital Stats Data. - Note: This is a one year rate for 2008. Previously reported data were reported as three year moving averages due to a small number of occurrences.

Notes - 2008

2008 Delaware Vital Stats Data. - Note: This is a one year rate for 2008. Previously reported data were reported as three year moving averages due to a small number of occurrences.

a. Last Year's Accomplishments

The contractor hired to assist the Bureau in absence of a CYSHCN Director interfaced with the Office of Highway Safety, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Emergency Medical Services for Children and the Injury Prevention Coalition continue to address motor vehicle related injuries and deaths as a priority area.				X
2. Home Visiting and Child Development Wachs complete safety assessments at clinic and home visits.		X		
3. State Service Centers offer child safety seat loaners to parents who cannot afford to purchase one.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau renewed its participation in the Delaware Injury Prevention Coalition at the March 2010 meeting. The MCH Director presented a thorough analysis that the Bureau had performed on DE OEMS trauma registry data. The group expressed interest in reduction of injury to youth aged 15-19, and MCH representation on the Coalition will continue to identify strategies to address injury prevention.

c. Plan for the Coming Year

The Bureau renewed its participation in the Delaware Injury Prevention Coalition at the March 2010 meeting and continued its commitment in 2011. The Division of Maternal and Child Health Bureau (MCH) recognizes the impact and importance of injury prevention. In support, MCH designated a staff member to the Delaware Coalition for Injury Prevention and as a member of the Safe Kids Delaware Coalition and this representation will continue in 2012. This enables MCH the opportunity to focus on data driven priorities shared with sister agencies, develop community partnerships to address childhood injuries and help establish initiatives to protect the youth of Delaware.

The Delaware Division of Public Health (DPH) supports a widespread network of violence and injury prevention partners, including the Coalition for Injury Prevention (i.e. Delaware's Injury Community Planning Group (ICPG)), which is a coalition made up of more than 50 representatives of 35 agencies. Membership includes state and local government, not-for-profit and private entities. The Delaware Coalition for Injury Prevention, currently facilitated by the

Office of Emergency Medical Services, a unit within the Division of Public Health, was an unfunded group until recently. In July 2011, Delaware was pleased to learn that our successful application was federally funded to develop a Violence and Injury Prevention Program (VIPP) under the Base Integration Component.

In 2012, as a result of the new grant award, the VIPP will work closely with the Family Health and Systems Management section of DPH, which also houses the Maternal Infant and Early Childhood Home Visiting Program and Maternal and Child Health/Title V Programs. The existing family health infrastructure ensures cohesion and is consistent with our strategic plans to emphasize linking and integrating public health programs in order to maximize protective factors and minimize risks across the lifespan.

The new CDC VIPP grant funding will be used to build program infrastructure and will help update the state injury prevention plan, engage a statewide coalition to bring about systems-level changes, and strengthen the injury surveillance and reporting within the state.

In 2012, MCH plans to collaborate with Safe Kids and the Office of Highway Safety to purchase car seats for a low-cost Child Safety Seat Program for the State of Delaware. The Bureau also plans to assist with Delaware's 2012 Safe Kids/Emergency Medical Services for Children Childhood Injury Prevention Conference.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	12	36	36	32	34
Annual Indicator	35.7	30.6	30.6	32.8	43.2
Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	44	45	45	46	46

Notes - 2010

2007 National Immunization Survey. Breastfeeding at 6 Months (n=268). Confidence Interval +/- 6.7%.

Notes - 2009

2006 National Immunization Survey (32.5% +/- 6.6%) - Any breastfeeding at 6 months of age.

Notes - 2008

2005 National Immunization Survey, CDC.

a. Last Year's Accomplishments

In 2008, DPH initiated a coordinated breastfeeding demonstration project at the Milford Health Unit. The voluntary program provides intensive case management, breastfeeding education and lactation consultant support to Smart Start and WIC clients. MCH funds expanded the pilot project within the Smart Start program, encouraging women to maintain breastfeeding through the first six months of an infant's life, and continues to be supported. Breast pumps, educational materials and other supplies are available to breastfeeding women. The second component of this project is the annual Breast is Best conference that 130 professionals attended in June 2010 and in 2011, its popularity is increasing with 198 professionals in attendance (i.e. MDs, RNs, RDs).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V is supporting the Breast is Best initiative. The program is an enhancement to the home visiting program and has a goal of 80% breastfeeding at 6 months of age.		X		X
2. In June 2011, the third annual statewide conference for medical professionals, "Breast is Best" was held.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Breastfeeding Coalition of Delaware, although established years ago, is finally growing its partnership base and is gaining strength, due to the leadership and support of Nemours Health and Prevention. In June, BCD launched a web site (<http://www.delawarebreastfeeding.org/>) that serves as a resource and support for the breastfeeding mothers in our First state. The Mission of the Coalition is to improve maternal and infant health by increasing the initiation and duration of breastfeeding, the gold standard for infant feeding. As a result of the coalition's recent efforts and a growing interest in improving breast feeding rates, two hospitals have recently signed Baby Friendly "Letters of Intent". Beebe Medical Center was the first to sign and more recently Bayhealth Medical Center. Bayhealth recently solicited the support of several DPH employees to sit in on their "Baby Friendly" planning meetings. DPH nurses participate as members of the Breastfeeding Coalition of Delaware. To achieve its mission, the Breast Feeding Coalition's goals are to:

- Increase public awareness of the benefits of breastfeeding for babies, mothers, families and communities.

- Educate professionals so they can better support the breastfeeding family.
- Promote communication and collaboration among individuals and organizations working to support breastfeeding.
- Promote development of the profession of International Board Certified Lactation Consultants.

c. Plan for the Coming Year

The Breastfeeding Coalition of Delaware, although established years ago, is finally growing its partnership base and is gaining strength, due to the leadership and support of Nemours Health and Prevention. In June 2011, BCD launched a web site (<http://www.delawarebreastfeeding.org/>) that serves as a resource and support for the breastfeeding mothers in our First state. The Mission of the Coalition is to improve maternal and infant health by increasing the initiation and duration of breastfeeding, the gold standard for infant feeding. As a result of the coalition's recent efforts and a growing interest in improving breast feeding rates, two hospitals have recently signed Baby Friendly "Letters of Intent". Beebe Medical Center was the first to sign and more recently Bayhealth Medical Center. Bayhealth recently solicited the support of several DPH employees to sit in on their "Baby Friendly" planning meetings. DPH nurses participate as members of the Breastfeeding Coalition of Delaware and plan to stay in engaged in 2012. To achieve its mission, the Breast Feeding Coalition's goals are to:

- Increase public awareness of the benefits of breastfeeding for babies, mothers, families and communities.
- Educate professionals so they can better support the breastfeeding family.
- Promote communication and collaboration among individuals and organizations working to support breastfeeding.
- Promote development of the profession of International Board Certified Lactation Consultants.

BCD hopes to continue to grow and strengthen, and is planning on holding a conference specifically targeting physicians as a fundraiser in the fall 2012.

DPH initiated a coordinated breastfeeding demonstration project at the Milford Health Unit, which has expanded statewide over the last year. The voluntary program provides intensive case management, breastfeeding education and lactation consultant support to the Smart Start home visiting program and WIC clients. MCH funds expanded the pilot project within the Smart Start program, encouraging women to maintain breastfeeding through the first six months of an infant's life, and will continue to be supported in 2012. Breast pumps, educational materials and other supplies are available to breastfeeding women. The second component of this project is the annual Breast is Best conference that 130 professionals attended in June 2010 and in 2011, its popularity is increasing with 198 professionals in attendance (i.e. MDs, RNs, RDs). Conference evaluations for the Breast is Best Conferences are overwhelmingly positive, and planning activities will occur over the next year for a fourth annual conference.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.4	93.7	98.7	99.4	99.4
Numerator	12147	11864	12468	12079	12079
Denominator	12342	12666	12627	12153	12153
Data Source			Delaware	Delaware	Delaware

			Newborn Hearing Screening Program	Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

The Newborn Hearing Screening Program worked closely with the Delaware Chapter of Hands and Voices to implement the Guide by Your Side Program. Guide by Your Side assists families with navigation of the early intervention system.

The Delaware Infant Hearing Assessment and Intervention Program Advisory Board has shifted its focus from merely increasing screening utilization to a more in depth planning and develop to ensure entry into early intervention services. Guide by Your Side will play a crucial role in this process.

The Newborn Hearing Screening Program has developed a protocol for tracking late on-set hearing loss among children through age 18.

The Program held the fourth annual "Delaware's Still Listening Conference" on March 18, 2010. Evaluations received from this event were very positive. The agenda included sessions for professionals and sessions for families of children with hearing loss.

The Program ran a statewide public service announcement on 5 cable television stations promoting newborn hearing screening and advertising the State's Hearing Aid Loaner Bank Program (a program that loans hearing aids and FM transmitters to children in families without adequate insurance or resources to purchase these items).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Delaware Early Hearing Detection and Intervention Program supports the Delaware Chapter of Hands and Voices and the Guide by Your Side program.				X

2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Delaware EHDI continued to support the Delaware Hands and Voices Chapter. The Delaware Hands and Voices Chapter is in the process of implementing the Guide by Your Side Program (GBYS). During the summer of 2010, initial training was completed for an initial cohort of family guides. The GBYS program provides support to families of children diagnosed with a hearing loss. This support includes education and guidance as the families make decisions regarding enrollment into appropriate early intervention services. The Delaware EHDI program continued to integrate the functions of its contractual services, particularly with respect to roles and responsibilities related to referral to- and entry into- early intervention services (contracted audiologists are developing a model for a "single point of entry" in concert with the Delaware Hands and Voices Chapter).

Delaware has initiated a pilot program to track children with late on-set hearing loss. In this pilot project, risk factors for late on-set hearing loss are collected. Delaware is using the 2007 Joint Commission on Infant Hearing Guidelines that consist of 11 risk factors. The project involves A.I. duPont Hospital for Children (Delaware's only children's hospital) and Christiana Care (Delaware's largest hospital).

Delaware has increased the scope of services under consultant audiologist contracts to improve quality assurance and develop a "single point of entry" system for enrollment into early intervention service

c. Plan for the Coming Year

Planned activities for the Newborn Hearing Screening Program for 2012 include the following:

- Developing research designs and determining the information needed, including data sources, data reliability and appropriate methods for analyzing and evaluating data;
- Analyze data for the EHDI program and other related child health programs; and
- Prepare comprehensive analytical and statistical reports.
- Developing interagency data agreements with birth sites, hospitals and diagnostic centers.
- Generating monthly reports on progress toward EHDI goals and objectives.
- Conducting technical assistance at birth sites, diagnostic centers and hospitals based on identified issues from data analyses.
- Developing guidelines for the reporting of data from diagnostic centers and medical homes by the sixth month of the first year.
- Developing and implementing a process for tracking referral to- and entry into- early intervention.

- Systematically collecting, inputting and analyzing data elements from the Late On-Set Hearing Loss pilot project and exploring options to implement this initiative statewide.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	8	8	12	10	9.2
Annual Indicator	12.3	12.3	10.5	9.4	8.5
Numerator	24992	24992			
Denominator	203188	203188			
Data Source			Kids Count Fact Book, 2009	2010 Kids Count Fact Book, 2009	2011 Kids Count Fact Book
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	8	8	7.8	7.8	7.8

Notes - 2010

This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2007-2009).

Notes - 2009

This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2007-2009).

Notes - 2008

This is a percent based on estimates from the Center for Applied Demography and Survey Research (Three year average 2006-2008).

a. Last Year's Accomplishments

The Delaware Health Care Commission oversees the Uninsured Action Plan. This plan explores strategies to preserve and expand health insurance coverage through the State Planning Program and linking uninsured citizens with reliable health homes and affordable care through the Community Healthcare Access Program (CHAP).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Community Health Access Program (CHAP) helps	X	X		

provide access to primary care doctors, medical specialists, and other health resources. Medical services are provided through Community-based Health Centers and private doctors.				
2. MCH Programs Provide SCHIP and Medicaid eligibility determination and referral.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We will continue to direct uninsured families and children to appropriate resources in the community for access to Federal Qualified Health Centers located throughout the state.

In 2010, Delaware Health and Social Services' Cabinet Secretary Rita Landgraf formed a Health Reform Workgroup, which is staffed by DPH, to provide strategic oversight on implementation and policy development. Many partners are included in this workgroup to address many opportunities such as health workforce development, public health evidenced-based home visiting programs, Medicaid, and insurance coverage to Delawareans as a result of the Health Reform law.

c. Plan for the Coming Year

Administrative oversight and management of the Community Healthcare Access Program (CHAP) program was structurally moved from the Delaware Health Care Commission to the Division of Public Health effective July 1, 2011. We do not expect significant changes to the program as it relates to children, but transfer of the program will allow for integration with DPH's cancer screening, navigation and health promotion activities generally. CHAP is Delaware's health system "safety net" and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology and laboratory services at reduced cost. Patients with incomes 200% of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance programs are matched with medical services provided through community hospitals, community health centers, and a network of over 500 private physicians who participate on a voluntary basis. Over the last couple of years, the existing CHAP infrastructure and service delivery of primary care and prevention activities were examined to explore coverage expansion and to find efficiencies (screening and eligibility, outreach, and enrollment). The findings determined that CHAP could play a key role in how federal reforms are implemented in Delaware and the overall delivery of health care, warranting the structural move to DPH.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	33	33	20	20	15
Annual Indicator	27.8	28.4	20.2	16.0	20.6

Numerator	2712	2814	2075	2075	2669
Denominator	9763	9920	10264	12962	12937
Data Source			Delaware WIC Program	Delaware WIC Program	Delaware WIC Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance Objective	20.4	20.2	20	19.8	19.6

Notes - 2010

Delaware WIC Program Data for Calendar Year 2010

a. Last Year's Accomplishments

The MCH Program partially funded the Planned Approach to Community Health (PATCH) Project in Sussex County. PATCH is a health promotion effort that provide community food drops, community grants, and community education and awareness about health issues, including diet, nutrition, exercise and obesity prevention in early childhood.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Division of Public Health partners with Nemours Health and Prevention Services on child health issues including obesity prevention				X
2. The DPH Health Promotion and Prevention Section has obesity prevention as a strategic initiative.				X
3. Nutritionists are part the MCH programs' staff. These programs include home visiting and Health Women, Healthy Babies.	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY 11, Childhood obesity was identified as a new State performance measure and priority during FY 2009 and the MCH program is currently considering additional initiatives around this issue, including the additional promotion of breastfeeding.

c. Plan for the Coming Year

The Home Visiting Program includes nutritionists on staff to promote health diets.

During the upcoming year the Early Childhood Comprehensive Systems program will renew its linkage with the Physical Activity, Nutrition and Obesity (PANO) program within the Division of Public Health.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	11	10.9	6.5	6.6	9.4
Annual Indicator	6.8	6.8	9.6	9.6	9.6
Numerator	814	814	1157	1157	1157
Denominator	11898	11898	12016	12016	12016
Data Source			Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	9.4	9.2	9	8.8	8.8

Notes - 2010

2008 Delaware Vital Statistics Data.

Notes - 2009

2008 Delaware Vital Statistics Data.

Notes - 2008

2008 Delaware Vital Statistics Data.

a. Last Year's Accomplishments

The comprehensive smoking cessation programs and services are having an impact on Delaware women. \

Delaware funds multiple interventions to reduce maternal smoking during pregnancy including:

- Healthy Women/Healthy Babies program aimed at recruiting women when they find out they are pregnant and providing services through the postpartum period;
- Preconception Care program aimed at recruiting non-pregnant women of childbearing age for care;
- Delaware Quitnet/Quitline focused on smoking cessation;
- DelaWELL program initiated to offer referrals to Delawareans who want to engage in healthier lifestyles;

- Delaware Tobacco Program created a specific social marketing campaign for OB/GYNs and primary care physicians who treat pregnant women. In addition to posters and educational materials, women are given a "quit kit" that includes stress relieving items and information about tobacco cessation support services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Smoking cessation continues to be a main risk factor reduction priority in each of the Maternal and Child Health programs. Women are provided counseling and educational materials to assist in smoking cessation.	X	X		
2. The MCH programs refer women to the Delaware Quitline, a statewide resource that offers support, counseling and vouchers for pharmaceutical products.	X	X		
3. Smoking during pregnancy continues to be monitored through the Registry for Improved Birth Outcomes.				X
4. The Health Women and Infants Consortium partners with community agencies to address the reduction of tobacco use among pregnant women and women of childbearing age.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The DPH Tobacco Prevention and Control Program has extensive and successful programs, health education, social marketing and resources for tobacco cessation for pregnant women. These include tobacco prevention programs such as "quit pack" which are given to OB and family practice providers statewide. In addition, Healthy Women Healthy Babies continues to offer mental health counseling for free for all women enrolled in the program. Counseling to these clients include addiction services, information and referral resources.

c. Plan for the Coming Year

The comprehensive smoking cessation programs and services are having an impact on Delaware women. In 2012, Delaware will continue to fund multiple interventions to reduce maternal smoking during pregnancy including:

- Healthy Women/Healthy Babies program aimed at recruiting women when they find out they are pregnant and providing services through the postpartum period;
- Preconception Care program aimed at recruiting non-pregnant women of childbearing age for care;
- Delaware Quitnet/Quitline focused on smoking cessation;
- DelaWELL program initiated to offer referrals to Delawareans who want to engage in healthier lifestyles;

The Delaware Tobacco Program created a specific social marketing campaign for OB/GYNs and primary care physicians who treat pregnant women, which will continue in 2012. In addition to posters and educational materials, women are given a "quit kit" that includes stress relieving items and information about tobacco cessation support services.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	5.5	5.4	5.4	13	8
Annual Indicator	13.5	8.3	3.4	3.4	3.4
Numerator	8	5	2	2	2
Denominator	59228	59899	59701	59701	59701
Data Source			Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	3.2	3.2	3	3	2.8

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

a. Last Year's Accomplishments

In December of 2009, the Division of Public Health was notified that School-Based Wellness Centers (SBWC) were not in compliance with current Medicaid reimbursement regulations. During the course of discussions on Medicaid billing with the various SBWC stakeholders the issue of providing reproductive health services at SBWC was discussed. As a result DPH revisited the issue of reproductive health services within SBWC. Although STD testing is provided in 75% of all centers, none provide contraception for routine pregnancy prevention. Although this issue was controversial, it merited a discussion with each school district to share the community specific epidemiologic data that supports delivery of full reproductive health services at each SBWC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. DPH clinic-based services provide referral for depression and other mental health conditions.		X		
2. School-Based Health Centers provide mental health counseling and referral to students.	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH Adolescent Health services developed a new model of service with an emphasize on the need to look outside of conventional reimbursement mechanisms to explore the feasibility of receiving reimbursement from private 3rd party payors and carried-out school district specific meetings with advisory boards and Parent Teacher Organizations to share community-level data about teen pregnancy, STDs and infant mortality.

DPH developed new consent forms including consents for reproductive health services for introduction into SBWC beginning in FY 12.

c. Plan for the Coming Year

In 2010, the Division of Public Health, (DPH) in collaboration with the Delaware Division of Medicaid and Medical Assistance, (DMMA); The Delaware Insurance Commissioner's Office and the School-Based Health Center, (SBHC) Medical Vendors developed the SBHC third-party billing guidelines. The guidelines provide the SBHC Medical Vendors with the procedures for submission of upper limit, cost information to DMMA; once submitted this information will allow for the establishment of a single unit rate that Medicaid will pay for services provided at the SBHC. Reimbursement from private insurance companies will be negotiated individually by each SBHC Medical Vendor and the private insurance companies.

The Division of Public Health through the SBHC are committed to providing services that benefit the adolescents of this state; services that encompass mental health screening including suicide ideation. SBHC utilize the American Medical Society, Guidelines for Adolescent Preventive Services (GAPS) to screen adolescents enrolled in their respective center. This comprehensive tool provides the SBHC staff with valuable information that is utilized in determining what services can best meet the needs of the student.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
---------------------------------------	------	------	------	------	------

Annual Performance Objective	90	90	80	80	92
Annual Indicator	79.3	90.5	77.5	77.5	77.5
Numerator	188	182	172	172	172
Denominator	237	201	222	222	222
Data Source			2007 Delaware Vital Statistics	2007 Delaware Vital Statistics	2008 Delaware Vital Statistics Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	78	78	78.2	78.4	78.6

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Vital Statistics Data

a. Last Year's Accomplishments

The Standards of Care committee worked with Delaware hospitals to establish a perinatal collaborative. The Delaware Healthcare Association (the hospital association) supports hospital and birthing center participation in this initiative. The collaborative is intended to advance practice standards including:

- Fetal 'Kicks Count' standards and campaign
- Appropriate administration of steroids to enhance fetal pulmonary maturity (including advancement of a common "Order Set for Preterm Admission")
- Progesterone administration for select women with a history of premature birth
- Control/oversight of infertility management
- Appropriate use of cerclage
- Avoidance of elective iatrogenic prematurity -- elective pre-39 week deliveries

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Delaware Healthy Mothers and Infants Consortium,				X

Standards of Care Committee monitors neonatal transport issues regarding transportation to the Level III facility.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Standards of Care Committee of the Delaware Healthy Mother and Infant Consortium continues to advance the perinatal collaborative (including the initiatives bulleted above), as well as, monitor neonatal transport issues in the state.

c. Plan for the Coming Year

Over the last year, Delaware established a Perinatal Cooperative and Dr. Garrett Colmorgen, a well-respected perinatologist and Mid-Atlantic appointee to the March of Dimes, is serving as the Medical Director to the Perinatal Cooperative (PC). The first meeting was held on February 17, 2011. In 2011, the Perinatal Cooperative will focus on three priorities: 1) fetal movement tracking education; 2) use of steroids to prevent preterm labor, and 3) safe sleeping..As needed, each of the DHMIC committees (Standards of Care, Health Disparities, will be utilized to support initiatives of the Perinatal Cooperative.

Over the next year, the Kicks Count Campaign will be a strategic focus and the distribution of materials will continue. Kicks Count materials have been added to the new Healthy Mothers Healthy Babies website (healthywomende.com). The website provides a wealth of information, including Kicks Count, the Teen Life Plan and the Adult Life Plan.

In 2012, the prematurity prevention program will continue to provide progesterone to women at risk of having a premature baby. Over the past year, the program helped 30 mothers who delivered at Christiana Health Care avoid premature labor and delivery.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	90	90	75	75	68
Annual Indicator	73.9	66.9	72.7	72.7	72.7
Numerator	8796	8092	8739	8739	8739
Denominator	11898	12097	12016	12016	12016
Data Source			Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	73	73	74	76	76

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

a. Last Year's Accomplishments

During 2010, the Healthy Women, Healthy Babies program model was implemented statewide. A new module was added to an existing data system (the Newborn Screening Data System) to collect individual level data elements related to program utilization and health outcomes. Previously data were reported in aggregate at the program level. With this new capability, the program can be effectively monitored and activities can be evaluated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Home Visiting Program engages women in early pregnancy , and provides cases management and follow-up services to ensure prenatal care is available and accessible.		X		
2. Prenatal programs provide transportation to non-English speaking women to reduce barriers to care.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Recently, DPH's MCH program established a relationship with the Sussex County Child Health Coalition to promote early prenatal care among Hispanic women.

High risk pregnant or post-partum women are referred to Home Visiting if a comparable program is not available at the health facility through Healthy Women, Healthy Babies. At risk or medically fragile infants are also served by Home Visiting. Targeted home visiting is employed as a venue to optimize individual responsibility, provide services and increase information.

c. Plan for the Coming Year

Fully implement HWHB and assess rates of early entry into prenatal care by geographic region. Work with the Sussex County site, La Red, to increase outreach to women and education about the necessity for early prenatal care. This includes the use of promotoras, or lay health educators.

MCH recently established a relationship with the Sussex County Child Health Coalition to promote early prenatal care among Hispanic women.

High risk pregnant or post-partum women will be referred to Smart Start if a comparable program is not available at the health facility through Healthy Women Healthy Babies. At risk or medically fragile infants are also served by Smart Start. Use targeted home visiting as a venue to optimize individual responsibility, provide services and increase information.

As a result of extensive and comprehensive planning, the Healthy Women Healthy Babies program is fully implemented and provides health care, mental health and nutrition services for women before, during and after pregnancy. Services are offered through 7 different health clinic providers in over 20 different locations throughout the state including 3 specifically located in Sussex County. The HWHB program is one of several infant mortality programs implementing the Life Course Model. This Life Course Perspective looks at the health of the mother from the day of her birth to the birth of her child. Programs are created around this model to implement multi-level initiatives for the woman herself, her family, her health care provider and her community.

D. State Performance Measures

State Performance Measure 1: *The rate of infant deaths between birth and 1 year of life.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				8	8
Annual Indicator	8.3	8.3	8.4	8.4	8.4
Numerator	99	99	101	101	101
Denominator	11898	11898	12016	12016	12016
Data Source			Delaware Vital Statistics	Delaware Vital Stats	Delaware Vital Stats
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	7.8	7.8	7.8	7.7	7.7

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

a. Last Year's Accomplishments

During 2010, the preconception and enhanced prenatal care program formerly known as the Family Practice Team Model was combined into one program. The program is now known as Healthy Women/Healthy Babies (HWHB). HWHB employs the life course model and incorporates a stronger focus on interconception care.

The CDC MCH epidemiology assignee returned to CDC in May 2009. Since June 2009, DPH has continued to contract with APS Health care to provide epidemiology, research and evaluation services for the family health programs within DPH. A large emphasis continues to be placed on research, analysis and evaluation of infant mortality elimination initiatives and those that target overall improvements in women's health before pregnancy -- preconception.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Preconception care and a lifespan approach to reproductive health are promoted through the Delaware Healthy Mother and Infant Consortium.	X	X	X	
2. Healthy Women, Health Babies provides wrap around services for at-risk reproductive age women	X	X		
3. Cribs for Kids provide safe sleeping promotion and free cribs to families who cannot afford do purchase one.	X	X		
4. Family Planning, STD Prevention	X	X	X	
5. Newborn Screening	X	X	X	
6. Growing Together			X	
7. PRAMS				X
8. Child Death, Near Death and Still Birth Commission				X
9. Fetal and Infant Mortality Review				X
10. Birth Defects Registry				X

b. Current Activities

- Provide health care, mental health and nutrition services for women before, during and after pregnancy through the Healthy Women Healthy Babies Program. During fiscal year 2010, six out of eight sites have entered data statewide serving 5,866 women across the state.
- Develop two reproductive health education tools, one for adults and one for teens, which aims to reach more than 100,000 in the first year. These toolkits are designed to help teens (youth between 15 and 18) and women identify their goals in life and write down specific steps for developing healthy relationships and healthy lifestyles. Using social media, the teen life plan is available at www.facebook.com/MyLifeMyPlan. A male reproductive health plan is under development.
- Provide genetic counseling for those at risk of having an infant born with a birth defect.
- Continue Kicks Count, a successful statewide awareness campaign dedicated to improving the chances of delivering a healthy baby by reducing stillbirth rates, which occur in one out of every 150 pregnancies nationwide. A tool kit has been designed to educate expectant parents about the importance of kick counting in monitoring a baby's health beginning at 24 weeks. This tool kit contains materials that will help expectant parents learn to track kick counts.
- 2011 Annual Maternal and Child Health conference, Enhancing the Future of Delaware reaches over 200 Delawareans

c. Plan for the Coming Year

Current Year Activities (Con't).

- Better serve our diverse population, by providing Spanish-language interpretation services for more than 500 patients per year.
- Immunizations and folic acid supplements, as well as health screenings for stress, intimate partner violence, exposure to toxins and drug/alcohol use are standard for all women served through the program.

We expect these programs to show results in prematurity, low birth weight and infant mortality over time. The infant mortality rate in Delaware dropped 10% from its peak of 9.3/1,000 births (2000--2004) to 8.4/1,000 births (2004--2008). Although there has been a long-term trend of increasing low birth weight babies, Delaware has had no increase since 2001. Preliminary 2008 Vital Statistics data indicate that Delaware had the 16th highest percentage of low birth weight births (births less than 2,500 grams) in the nation at 8.5%. Delaware had the 16th highest preterm birth rate (less than 37 weeks of completed gestation) in the nation at 12.9% according to preliminary 2008 data.

Plan for the Coming Year

Continue implementing reproductive life planning education and awareness for adults and teens. During this coming year the Delaware Healthy Mother & Infant Consortium in partnership with DPH will create a reproductive life plan for men. Additionally, training materials on the Life Course Perspective will be created to promote awareness of this paradigm among primary care and women's health medical professionals.

State Performance Measure 2: *The rate of live births at 32 to 36 weeks of gestation(preterm birth).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				110	108
Annual Indicator	112.4	112.4	102.5	102.5	102.5
Numerator	1337	1337	1232	1232	1232
Denominator	11898	11898	12016	12016	12016
Data Source			Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	106	106	105	105	104

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

a. Last Year's Accomplishments

During 2010, Delaware implemented a social marketing campaign to develop a prematurity awareness among African American women of reproductive age. In order to reduce the number

of infant deaths in Delaware, the number of premature births must be reduced. The awareness campaign targets the following misconceptions:

- Prematurity isn't that bad.
- Small babies do just fine in the NICU.
- Having a baby born before 40 weeks is easier on the mom.
- It is chic or cute to have a really small baby.

Reproductive life plans have been developed as part of a statewide social marketing campaign.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Preconception Care	X	X	X	
2. Healthy Women, Healthy Babies	X	X		
3. Family Planning	X	X	X	
4. PRAMS				X
5. Center for Family Health Research and Epidemiology				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activities this year included concerted outreach and awareness about the dangers of prematurity, specifically among members of the state legislature. The rate of prematurity in Delaware is higher than the national average and often it is not understood that prematurity is the largest single contributor to Delaware's higher infant mortality rate. The educational campaign "We Need Your Help" made the cost case to raise awareness about the cost to Medicaid and to society of Delaware's high prematurity rate. The prematurity rate was provided for each house and senate district to make the information applicable to the legislator.

c. Plan for the Coming Year

The Perinatal Cooperative will work to establish standards of care for the treatment of preterm labor with the goal of preventing prematurity. This includes the appropriate use of steroids for women who present with signs of preterm labor. Additionally, the Prematurity Prevention Program will continue promoting awareness among 100% of all OB/GYN providers about progesterone and offering it free to patients without insurance or means to pay for the drug.

State Performance Measure 3: *The rate of low birth weight and very low birth weight deliveries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				92	90
Annual Indicator	94.0	94.0	84.9	84.9	84.9
Numerator	1119	1119	1020	1020	1020
Denominator	11898	11898	12016	12016	12016

Data Source			Delaware Vital Statistics	Delaware Vital Statistics	Delaware Vital Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	84	84	83	83	82

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

a. Last Year's Accomplishments

During FY 2010, Delaware continued a Statewide Education Campaign. This campaign developed and distributed resources for educating teens and adult women on subjects relating to infant mortality. The initiative continued to distribute the Reproductive Life Plan toolkits to help teen and adult women set and follow personal goals that assist in achieving healthy pregnancies, when and if desired.

Maternal and Child Health Programs continued to support of the efforts of the Tobacco Prevention and Control Program to ensure all pregnant women have access to tobacco cessation counseling and services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Preconception Care	X	X	X	
2. Healthy Women, Healthy Babies	X	X		
3. Family Planning	X	X	X	
4. PRAMS				X
5. Center for Family Health Research and Epidemiology				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2011, Delaware continued a multi-level approach that involves the individual woman, her family, her health care provider and the community in striving for optimal reproductive health through the Healthy Women/Healthy Babies program.

In the age of enhanced technology to capture and utilize data to tell a story, the Family Health and Systems Management Section had the foresight to develop a web-based patient tracking and data reporting collection module for the Healthy Women/Healthy Babies (HWHB) program. HWHB program providers are required to submit individual level data on all women served with preconception, prenatal, postpartum and inter-conception services. The additional module joins the Case Management System for the Newborn Metabolic, Hearing and Birth Defects Registry programs. Services are targeted to women who are African American, whose most recent pregnancy had a poor birth outcome (premature birth, stillbirth, low birth weight delivery or infant death), those with chronic diseases, late entry into prenatal care or less than high school

education.

c. Plan for the Coming Year

In 2012, we will continue the new science-based preconception/interconception and prenatal program, Healthy Women/Healthy Babies, to address the health of the mother from the day of her birth to the birth of her child. This multi-level approach involves the woman herself, her family, her health care provider and the community. Continue to collect and analyze data on the health of pregnant women, fetal deaths, infant deaths and birth defects. We now have a better understanding than ever about why Delaware's infant mortality rate is so high. Through the prematurity prevention program, Delaware will continue to provide progesterone to women at risk of having a premature baby. Over the past year, the program helped 30 mothers who delivered at Christiana Care avoid premature labor and delivery.

State Performance Measure 4: *The percent of children and adolescents who are overweight or obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				16	16
Annual Indicator		17	33.2	33.2	33.5
Numerator					
Denominator					
Data Source			2011 KIDS Count Fact Book	2011 KIDS Count Fact Book	2011 KIDS Count Fact Book
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	33	33	32	32	31

Notes - 2010

Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative

Notes - 2009

Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative

Notes - 2008

Childhood Obesity Action Network. State Obesity Profiles, 2009. National Initiative for Children's Healthcare Quality, Child Policy Research Center, and Child and Adolescent Health Measurement Initiative

a. Last Year's Accomplishments

The Physical Activity, Nutrition and Obesity (PANO) program within the DPH Health Promotion and Disease Prevention Section has moved forward with limited state funding to develop and implement a statewide plan.

PANO formed the Delaware Coalition for Healthy Eating and Active Living (DE HEAL) to assess and implement programs in DE. The DE HEAL (Delaware Coalition to promote Healthy Eating and Active Living) continued efforts to achieve their goals and objectives. The goals are to:

- Increase physical activity
- Increase the consumption of fruits and vegetables
- Decrease the consumption of sugar-sweetened beverages
- Increase breastfeeding initiation and duration
- Reduce the consumption of high-energy-dense foods
- Decrease television viewing

The statewide coalition has established seven committees/workgroups. These include:

- Community-based programs
- School/Youth
- Environment
- Industry/Employee Health
- Policy and Legislation
- Health Care Delivery
- Research and Evaluation

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC	X	X	X	
2. School-Based Wellness Centers	X	X	X	
3. ECCS				X
4. Breastfeeding Promotion			X	
5. Home Visiting	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The PANO program was awarded ARRA (American Reinvestment and Recovery Act) Communities Putting Prevention to Work (CPPW) funds to do the following:

- To develop and implement procedures for healthy food choices for Delaware State Parks that provides healthy eating choices and limits the availability of unhealthy foods for all parks and park facilities through procurement practices and competitive prices in the vending machines, campground shops, and concession stands.
- To work with the Delaware Department of Transportation to improve signage for bicycle routes and bicycle facilities.

PANO established a very successful Farmers' Market to promote locally grown fruits and vegetables and began it's third year in 2011.

c. Plan for the Coming Year

Continue the successful weekly farmer's market in the green space near the state legislative building.

The Physical Activity, Nutrition and Obesity Prevention Program (PANO) is continuing efforts under two federal grant projects: 1) American Reinvestment and Recovery Act (ARRA) Communities Putting Prevention to Work; and 2) Healthy Communities. Some highlights from these programs, which will continue over the next year, include:

- University of Delaware Institute for Public Administration (IPA) recently released the Health Impact Assessment tool (HIA). The HIA was created as a supplement to Healthy Communities: A Resource Guide for Delaware Municipalities. The purpose of this quick guide is to introduce health impact Assessment which is an exciting and relatively new analytic approach to planning healthier communities. The HIA is on are on the IPA toolkit website at www.ipa.udel.edu/healthyDEtoolkit/.
- IPA has been an instrumental resource to Delaware communities and provides technical assistance and training in community needs assessments, walkability assessments and to the Delaware Coalition for Healthy Eating and Active Living (DE HEAL)
- IPA provided technical assistance to the DE HEAL Environment and Policy committee to develop GIS maps for food deserts in Delaware. These maps were presented at Access to Healthy Foods in the Built Environment forum sponsored by the DE HEAL Environment and Policy setting and the Delaware Chapter of the American Planning Association, with support from DPH. The forum was held on May 24, 2011, in New Castle County. The forum identified food access issues in urban settings and explored solutions moving into the future.

The Delaware Farm to School program helps farmers sell their fresh produce to schools across the state. The program started in 2010 and plans to expand over the next year. By providing fresh food to students, kids can learn about what locally grown foods are available during each season. Students are given healthier food choices at lunch. Every school district in Delaware is participating in the Farm to School program, which is a great achievement.

State Performance Measure 5: *The percent of women of childbearing age (15-44) who are obese (BMI 30 or higher).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				26	26
Annual Indicator		27	27	27	27
Numerator					
Denominator					
Data Source			Delaware BRFSS	Delaware BRFSS	Delaware BRFSS
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015

Annual Performance Objective	25	25	24	24	23
------------------------------	----	----	----	----	----

Notes - 2010

Percent of women 25-34, 2007 YRBS

Notes - 2009

Percent of women 25-34, 2007 YRBS

Notes - 2008

Percent of women 25-34, 2007 YRBS

a. Last Year's Accomplishments

The Infant Mortality Elimination program and DHMIC are develop a preconception social marketing campaign. A significant message of the campaign is the need to achieve a healthy weight before pregnancy. Novel messaging and distribution via new media (e.g. text messaging, blogs) promoted widespread dissemination of this message to women of childbearing age.

In addition, the Healthy Women, Healthy Babies program provided nutritional counseling to all overweight and obese women. The women were eligible to meet with a Registered Dietician to develop individual healthy eating and healthy weight goals.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Home Visiting	X	X		
2. Preconception Care	X	X	X	
3. Family Planning	X	X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Infant Mortality Elimination program and DHMIC have developed a preconception social marketing campaign. A significant message of the campaign is the need to achieve a healthy weight before pregnancy. Novel messaging and distribution via new media (e.g. text messaging, blogs) promotes widespread dissemination of this message to women of childbearing age.

In addition, the Healthy Women, Healthy Babies program provides nutritional counseling to all overweight and obese women. The women are eligible to meet with a Registered Dietician within their current care setting to develop individual healthy eating and healthy weight goals. Impact evaluation on an individual-level will take place during the upcoming year.

c. Plan for the Coming Year

The Healthy Women/Healthy Babies Program, aimed at serving women for preconception care, prenatal care and interconception care will be continued over the next year. All women in the program have access to free services from a Registered Dietician. They give women the tools to learn to maintain a healthy weight, eat a nutritious diet, including adequate amounts of folic acid

daily, managing chronic disease, as well as being tobacco and substance free.

Smart Start/Healthy Families America: Public Health nurses, nutritionists and social workers provide enhanced prenatal care via home visits. In addition, clients are offered nutritional counseling for women who need additional services beyond what the nurse is able to provide.

Women, Infant, and Children (WIC) Program: Promotes healthier eating habits. WIC is a federally funded program that safeguards the health of low-income pregnant, breastfeeding and postpartum women, and infants and children five years of age. The program provides nutritious foods, information on healthy eating, breastfeeding support, and referrals to other healthcare, welfare and social services.

The PANO program, in collaboration with the DE HEAL Families in Communities committee, is completing the first phase of the Municipal Wellness Leadership Program with three municipalities in the state, and will continue expanding over the next year. The purpose of the MWL is to conduct a community needs assessment and an environmental scan. The municipalities received training by the PANO Program on the CDC evidence-based CHANGE Tool model for use in identifying gaps in programs and policy, systems and environmental strategies for chronic disease prevention.

The Sussex County Health Promotion Coalition (SCHPC) is a group of active partners working in the largely underserved and low-income areas of western Sussex County, and will continue to stay actively engaged. The SCHPC was recently awarded an ACHIEVE (Action Communities and Innovation for Environmental Change) grant. The DPH PANO Program Administrator is also the ACHIEVE State Health Department Expert Advisor and provides state-level technical support to the coalition.

DE HEAL Coalition Annual Meeting- On May 12, 2011, the DE HEAL Coalition's held its Annual Meeting. Setting Chairs/Co-Chairs of the Leadership Team presented their annual accomplishment reports at the meeting. This meeting was concluded with the changing of leadership for the coalition. With the installation of the New Leadership Team for 2011-2012, new goals and activities will be established.

State Performance Measure 6: *The mortality rate among children and youth (0-21 years) due to unintentional injuries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				10.5	10.5
Annual Indicator		16.1	12.8	12.8	12.8
Numerator			32	32	32
Denominator			250636	250636	250636
Data Source			Delaware Health Statistics	Delaware Health Statistics	Delaware Health Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	12.6	12.6	12.4	12.4	12.2

Notes - 2010

2008 Delaware Vital Statistics

Notes - 2009

2008 Delaware Vital Statistics

Notes - 2008

2008 Delaware Vital Statistics

a. Last Year's Accomplishments

The contractor hired to assist the Bureau in absence of a CYSHCN Director interfaced with the OHS, Office of Emergency Services (OES) and the Delaware Injury Prevention Coalition (DIPC) to review and analyze data and best practices relating to this indicator. The Bureau also worked with Children's Safety Network for technical assistance. In addition to participation in DIPC, the Bureau was an active collaborator of the Safe Kids Coalition. Safe Kids Delaware is a non-profit organization established in 1989 comprised of volunteers dedicated to reducing unintentional childhood injury in children from birth to age 14. Throughout the year SK held multiple safety awareness events, educational activities and injury prevention health fairs and conferences.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Injury Prevention Coalition, a group consisting of many state and community-based agencies continues to promote injury prevention awareness throughout the state.			X	X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A Strategic Plan for Injury Prevention (2005-2010) has been developed by expert work teams from the Delaware Coalition for Injury Prevention with guidance from the Division of Public Health's Office of Emergency Medical Services. The plan provides a framework to address nine core injuries: falls, motor vehicle injuries, traumatic brain and spinal cord injuries, suicide and suicide attempts, poisoning, fire injuries, dog bites, firearm injuries, and drowning and submersion injuries. The work teams used the public health approach to define each problem, identify risks and causes, and develop interventions to increase the public's awareness about the preventability of these injuries. The plan also seeks to reduce environmental risks, impact public policy and decision-making, and redirect the economic and social losses caused by injury. Over the next year, MCH will work with the Delaware Coalition for Injury Prevention on implementing strategies identified in the state plan.

Home visiting by nurses to families at high risk of injury is used in Delaware for a wide range of

purposes, including improving the home environment, family development and addressing child behavior. Improvement in the quality of the home environment is associated with a reduced risk of some types of injury, for example falls in very young children, with the greatest impacts found in programs using professional visitors with longer visitation schedules and those supplying and explaining safety devices.

c. Plan for the Coming Year

The Bureau will continue to focus on passenger safety within the realm of unintentional injury/mortality prevention in the coming year. As a result of the new Violence and Injury Prevention Program grant, the MCH Deputy Director and staff will get more involved and shape the specific emphases and interventions within these performance measures overall. The Bureau will continue to actively participate in the DIPC and collaborate in all possible ways. Additionally, the Bureau will continue its role and partnership with the Safe Kids Coalition. The Delaware MCH Bureau is involved in the Motor Vehicle workgroup as a part of its needs assessment to analyze severity of motor vehicle crash-related injury data for children and youth who are treated at a hospital. The coalition is divided into several risk areas that report information each quarter on actions, and upcoming plans. The risk areas are listed below with example 2011-12 activities:

- Dog Bites -- hold Literacy Education Assistance Pups - "Love your Dog - Leash Your Dog."
- Drowning/Submersion -- Researching C-Spine surf injuries. Produced short pool safety video.
- Fires/Burns -- \$15,000.00 received by each county to purchase smoke alarms that will be distributed as a part of Fire Prevention Month. Children from the state of Delaware ages 6 - 18 that have sustained serious burn injury are invited to attend Delaware Burn Camp. The mission of the Delaware Burn Camp is to assist young burn victims from the State of Delaware in their adjustment to injury through the provision of a safe, supportive environment and providing companionship through physical and social activities in a camp setting.
- Motor Vehicles -- Offering car seat safety checks in all 3 counties; presentations on the Graduated Drivers License program; and offering "mock-tail" parties around the state throughout the holiday season.
- Poisonings
- Suicide/Suicide Attempts-- Depression screening offered throughout state. Delaware Suicide Gatekeeper Training "Project Life (Living is for everyone)" classes held in all 3 counties.
- Traumatic Brain Injuries/Spinal Cord Injuries -- 200 bike helmets and T-shirts were given out as part of a stay safe campaign. Every child caught wearing a helmet received a "Rita's Ice" during the "Caught You being Safe" program.
- Violent Injury: Assault, Firearm, Homicide -- 13 boys signed up for the Kindergarten through 10th grade Fire Arm Safety course. Approximately 20 students attended the anti-bullying safety-program in Sussex County where they have partnered with the First State Community Action committee, which plans to conduct more programs for that community. Additional neighborhoods were identified as areas where people are concerned with the same topics. Community safety surveys were completed to assist with identification of areas on concentration and subject matters such as gang-related drive-by shootings.

State Performance Measure 7: *The percent of Delaware public high school students who currently smoke.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				10	10
Annual Indicator	18.2	18.2	19.1	19.1	19.1
Numerator					

Denominator					
Data Source			Delaware YRBS	Delaware YRBS	Delaware YRBS
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	18.8	18.8	18.6	18.6	18.4

Notes - 2010

2009 YRBS

Notes - 2009

2009 YRBS

Notes - 2008

2009 YRBS

a. Last Year's Accomplishments

During 2010, according to the latest BRFSS and YRBS data, the adult smoking rate reached an all-time low of 17.8% and the high school smoking rate plunged to its lowest rate of 17.3%. More than 3,500 adult Delawareans enrolled in cessation counseling services: 2,346 chose Quitline (telephone); 1,773 chose face-to-face counseling; and 1,211 enrolled in Delaware Quitnet (web-based). The Tobacco Prevention Program awarded 31 community grants that will engage more than 11,500 youth and 6,200 adults in tobacco prevention activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Teens Against Tobacco Use training and public education			X	
2. Delaware Kick Butts Generation youth empowerment programs		X		
3. Youth tobacco cessation program		X		
4. Quitline and Quitnet tobacco cessation program		X		
5. Reproductive Life Plans			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The high school smoking rate continues to drop and as of the 2010 YTS the rate is 14.9. More than 3,500 adult Delawareans enrolled in cessation counseling services; 3,315 chose Quitline (telephone); 386 chose face-to-face counseling (FY11 numbers for Delaware Quitline). There were 32 mini-grants awarded to community organizations statewide. The majority of the mini grant awards (26) focused on youth prevention activities. Through the contract with American Lung Association, several youth prevention activities have taken place such as Teens Against Tobacco Use (TATU) and the youth empowerment group, entitled Delaware Kick Butts. Generation has over 40 interns working for the cause with over 8,000 active members.

c. Plan for the Coming Year

Delaware is excited to report that the my7minutes website (www.my7minutes.com), a project of the Division of Public Health (DPH), generated over 27,000 hits during the entire reporting period (March 2010- March 2011), with 630 youth establishing accounts and 283 submissions of artwork and other content. In addition, DPH ran two contests on the website to solicit input on the development of advertisement campaigns. One anti-tobacco design was selected to appear on a T-shirt that was distributed to 1,500 kids, ages 14 and under at a Wilmington Blue Rocks (Delaware's minor league baseball team) game. The game was sponsored by IMPACT (Delaware Tobacco Prevention Coalition). Another contest winner submitted a tobacco prevention script for a tobacco prevention television commercial. In 2012, the commercial will be produced using teens from a local high school.

Counseling: Due to demonstrated measurable success, DPH will continue to offer free tobacco cessation counseling through the Delaware Quitline.

DPH also has a Quitnet program, which it will continue over the next reporting period, which is dedicated to providing comprehensive resources and support for people trying to stop smoking. The program consists of: learning from science-based smoking cessation resources, getting quitting tips and advice from expert counselors, getting quit support from the QuitNet community and creating a personal quit smoking plan.

In collaboration with Delaware healthcare providers, teenagers are encouraged to abstain from smoking or to quit if they currently smoke. The question is asked on paperwork given at providers' offices. If the teen is having trouble quitting, providers can prescribe prescription medication or recommendations of over-the-counter nicotine replacement treatments.

Furthermore, School-Based Health Centers will continue as a resource for teens to receive information on quitting and counseling from trained professionals.

Anti-Ash Brigade (AAB): This initiative is aimed at kids in grades 4-6. The AAB is a Delaware youth movement for children aged 8-12, dedicated to promoting the understanding of the dangers of tobacco use. The AAB is committed to decreasing the initiation of tobacco use through educational programs kids will understand. The AAB teaches Delaware youngsters how to avoid falling into the tobacco-use trap, handle-peer pressure and truly understand the dangers of tobacco use. Through age appropriate educational, social, and advocacy efforts, led by DPH, AAB members will become healthy lifestyle advocates.

State Performance Measure 8: *The percent of benchmark measures completed for implementation of a formal umbrella structure for organizations serving families with children with special health care needs in Delaware.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				60	80
Annual Indicator			20.0	60.0	80.0
Numerator			1	3	4
Denominator			5	5	5
Data Source			State Title V Program Data	State Title V Program	State Title V Program
Is the Data Provisional or Final?				Final	Final
	2011	2012	2013	2014	2015
Annual Performance	100	100	100	100	100

Objective					
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a. Last Year's Accomplishments

A RFP was issued in November of 2009 and the contract was executed with a March 2010 start date. The Bureau met with the contractor, University of Delaware, Center for Disabilities Studies, to firmly guide the overarching goals of the Family Support Initiative.

The UDS-CDS work plan during FY 2010 included:

- A group meeting of probable collaborators to launch effort and solicit public input into Needs Assessment
- Conducting a comprehensive environmental scan
- Facilitating a Collaborator's Summit
- Web and print (large print, Braille and audio) information resources
- Communication of emerging issues, opportunities

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Initiative				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2011, work with the FSI continued including: support in promotion of the state mixed-methods CYSHCN survey; continued family input into Bureau plans; and work on a State Transition Plan. Additionally, the contractor for FSI, UDS-CDS, conducted an environmental scan process designed to elicit all services and access information for CYSHCN providers as a principal goal.

c. Plan for the Coming Year

The Family SHADE activities planned for current year will likely extend into next federal FY. The next series of deliverables will include a second environmental scan to assess organizational capacity (e.g., governance), support in promotion of the state mixed-methods CYSHCN survey, continued family input into Bureau plans, and the planning and implementation of several activities proposed in the State Implementation Grant to Improve Services to Children and Youth with Special Health Care

Needs.

State Performance Measure 9: *The percentage of children aged 4 months to 5 years with no or low risk for developmental, behavioral or social delays.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective				76	76
Annual Indicator			74	74	74
Numerator					
Denominator					
Data Source			NSCH, 2007	NSCH, 2007	NSCH, 2007
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	78	78	80	80	82

Notes - 2010

2007 National Survey on Children's Health

Notes - 2009

2007 National Survey on Children's Health

Notes - 2008

2007 National Survey on Children's Health

a. Last Year's Accomplishments

With the passage of HB 199, the groundwork has been laid to improve developmental screening in Delaware. However, additional efforts in the area of awareness, promotion and technical assistance are necessary to increase the number of pediatricians and family practice providers who offer structured screenings at 9, 18 and 36 months of age, as recommended by the American Academy of Pediatrics.

In December 2010, the Division of Public Health received a \$20,000 grant through the W. K. Kellogg Foundation (Connecticut Help Me Grow) for implementation of a centralized telephone hotline for child services. Delaware is developing a plan to implement the Help Me Grow system, with developmental screening as major component. Some next steps are provided below:

- Gain consensus on tools to be promoted -- ASQ and PEDS.
- Provide training on why, what, when and how for screening. Trainings should be offered in-person, within practice sites and on-line.
- Provide technical assistance on workflow, incorporate of tools into electronic medical records, billing and parent engagement.
- Provide clear direction and guidance on referral sources -- specifically what to do when the screening reveals a potential developmental delay.
- Leverage the Help Me Grow model to increase parent awareness and demand for developmental screening and linkage to behavioral and developmental services. Help Me Grow can also serve as a referral source for providers and for families navigating and finding early childhood services and resources.
- Many stakeholders in Delaware are interested and invested in promoting adoption of structured developmental screening and replication of the Help Me Grow system. These include:
 - o DPH Title V MCH -- Early Childhood Comprehensive Systems
 - o Nemours Health and Prevention

- o Delaware Chapter of AAP
- o Early Intervention- Part C
- o UD Center for Disabilities Studies -- Learn the Signs Act Early
- o Autism Delaware
- o Delaware Early Childhood Advisory Council

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early Childhood Comprehensive Systems initiative collaborates with partners throughout the state to strengthen early childhood developmental screening and interventions in a number of settings.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In December 2010, the Division of Public Health received a \$20,000 grant through the W. K. Kellogg Foundation (Connecticut Help Me Grow) for implementation of a centralized telephone hotline for child services. Delaware is developing a plan to implement the Help Me Grow system, with developmental screening as major component. Some next steps are provided below:

- Gain consensus on tools to be promoted -- ASQ and PEDS.
- Provide training on why, what, when and how for screening. Trainings should be offered in-person, within practice sites and on-line.
- Provide technical assistance on workflow, incorporate of tools into electronic medical records, billing and parent engagement.
- Provide clear direction and guidance on referral sources -- specifically what to do when the screening reveals a potential developmental delay.
- Leverage the Help Me Grow model to increase parent awareness and demand for developmental screening and linkage to behavioral and developmental services. Help Me Grow can also serve as a referral source for providers and for families navigating and finding early childhood services and resources.
- Many stakeholders in Delaware are interested and invested in promoting adoption of structured developmental screening and replication of the Help Me Grow system. These include:

- o DPH Title V MCH -- Early Childhood Comprehensive Systems
- o Nemours Health and Prevention
- o Delaware Chapter of AAP
- o Early Intervention- Part C
- o UD Center for Disabilities Studies -- Learn the Si

c. Plan for the Coming Year

The Early Childhood Comprehensive Systems (ECCS) initiative will continue to work the Delaware Chapter of the American Academy of Pediatrics, the Home Visiting Community

Advisory Board and other partners toward a statewide implementation of developmental screenings using a validated screening tool.

In April 2011, the Commonwealth Fund State Scorecard on Child Health System Performance ranked Delaware 50th (lowest) for the percent of young children (ages 10 months-5 years) who received standardized developmental screening during visit. The data is based on the 2007 National Survey of Children's Health (NSCH) where Delaware's percent of children screened was 10.9% compared to the national percentage of 19.5%. While there is no indication that the data is inaccurate, it is important to note that the National Survey of Children's Health is a phone-based survey. In response to these findings, a proposal was submitted to the Lieutenant Governor Matt Denn to increase the use of validated development screening tools, which was successfully funded in FY12 State budget process. Over the next year, the PEDS tool will be made available online to families to complete the assessment. PEDS Online is a web-based tool that allows parents to complete an assessment which is then securely transmitted to the provider. This assessment can be done before the office visit, saving valuable time and resources. Additionally, providers can score the tool, print parent education send automated referral letters, and store the results in an electronic medical record. Nemours Health & Prevention services will provide on-site training and technical assistance to provider practices implementing standardized screening. Information and resources are also made available through the Delaware Chapter of the American Academy of Pediatrics.

In 2012, Delaware plans to work on the planning and implementation of a Help Me Grow system. Help Me Grow, serves as a comprehensive and integrated statewide system designed to address the need for early identification and linkage to developmental and behavioral services and supports for the birth through age eight populations. To effectively accomplish establishing Delaware's HMG system, coordination of efforts with several stakeholders will include the development of four key components: 1) centralized telephone access point; 2) community outreach to promote use of DE-HMG; 3) physician outreach to support early screening and intervention; and 4) data collection (surveillance, case management, referrals, follow-up) to identify gaps and barriers impeding the current system. The project will be further integrated with the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting program, the Children and Youth with Special Health Care Needs activities, and other early childhood related activities to improve young children's health and development to ensure success in school and throughout the lifespan.

State Performance Measure 10: *The percent of health indicators that improve across four domains (child health, mental health, health care access and quality, and family health) for children with special health care needs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Provisional	Provisional
	2011	2012	2013	2014	2015
Annual Performance Objective	20	20	30	30	30

Notes - 2010

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

Notes - 2009

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

Notes - 2008

The indicators for the index measure are derived from the National Survey of Children's Health. Baseline data was established from the 2007 NSCH Survey (NSCH Health Disparities Snapshot). For the indicators selected at baseline, CSHCN and their families were significantly different than children and their families without special health care needs. Since this is a measure based on improvement - reducing the disparities between CSHCN and those without special health care needs, the baseline indicator for 2011 is set at zero (0).

a. Last Year's Accomplishments

This is a developmental State Objective that was implemented in Federal Fiscal Year 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Initiative				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This is a developmental State Objective that was implemented in Federal Fiscal Year 2011. We will not be able to establish a baseline until the next National Children with Special Health Care Needs Survey is released. This NPM is designed to be an index measure of each of the CSHCN national and state measures.

c. Plan for the Coming Year

We will continue to monitor this measure, as appropriate, and establish a baseline when the next round of survey data becomes available.

E. Health Status Indicators

Introduction

As a leading contributor to infant mortality, Delaware has focused its efforts on reducing the number of low birth weight and very low birth weight infants. The Infant Mortality Initiative supports an enhanced preconception, prenatal and interconception care program for at risk women. Since 2007, the program has extended to sites throughout the state, including a larger urban OB/GYN practice that serves primarily African American women. The program focuses on providing high-quality holistic medical, social, nutrition and mental health services.

Reducing the number of low and very low birth weight infants will remain of primary focus in FY11. This includes a media campaign focused on enhancing awareness about the dangers of prematurity and expanding the number of women served statewide.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.3	9.2	8.5	8.5	8.5
Numerator	1112	1118	1020	1020	1020
Denominator	11898	12097	12016	12016	12016
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Low birth weight deliveries affect 1 in 14 babies born in the United States each year and can cause both immediate and long-term problems (Low birthweight newborns, 2002). Nationally, the low birth weight rate has increased from 7.0 in 1990 to 8.2 percent in 2005, representing a 17.1% increase (CDC, 2007). As the low birth weight rate has increased, the disparity ratio has remained consistently high. Non-Hispanic black women are nearly twice as likely to give birth to low birth weight babies compared with non-Hispanic white women (disparity ratio = 1.9) (CDC, 2007).

Delaware has the eighth worst infant low birth weight percentage in the nation (Kids Count Data Center, 2005). The percentage of low birth weight infants born in Delaware continued to increase in the early 2000s to 9.3% in the 2006 before dropping slightly to 9.2% in 2007 (Delaware Health Statistics Center, 2006, 2007).

National objectives for low birth weight include the Healthy People 2010 objective for improving

maternal, infant, and child health: 16-10 Reduce low birth weight and very low birth weight deliveries (Healthy People 2010). Like the U.S., strategies aimed at reducing low birth weight in Delaware are found as components of infant mortality prevention initiatives. Reducing the prevalence of risk factors associated with poor birth outcomes, such as low birth weight deliveries, is a Delaware Healthy 2010 goal (Healthy Delaware 2010). The state of Delaware funds the following interventions to reduce infant low birth weight:

Healthy Women, Healthy Babies program provides preconception, prenatal care and case management services to women and pregnant women at-risk for poor birth outcomes during the preconception/interconception and prenatal periods.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	7.3	7.6	6.8	6.8	6.8
Numerator	833	885	785	785	785
Denominator	11452	11712	11590	11590	11590
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Premature birth and fetal growth restriction are the two main causes of low birth weight deliveries (March of Dimes, n.d.). Preterm labor results in the premature birth of a low birth weight infant. Multiple pregnancies can lead to fetal growth restriction and subsequent low birth weight deliveries. Other factors that may increase the risk of giving birth to a low birth weight infant include maternal medical risks, substance use during pregnancy, inadequate weight gain during pregnancy, placental problems, and socioeconomic factors such as low income and lack of education. Prenatal smoking and alcohol consumption can limit fetal growth and result in low birth weight deliveries (DHHS, 2004; ACOG, 2000; Berghella, 2007). Pregnant women who smoke are nearly twice as likely to deliver a low birth weight infant compared with non-smokers (March of Dimes, n.d.).

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	2.0	1.7	1.8	1.8	1.8
Numerator	237	201	222	222	222
Denominator	11898	12097	12016	12016	12016
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

In Delaware, during the 2002-2006 time period, the primary cause of infant death was prematurity and low birth weight deliveries (Infant Mortality, 2006). Infant low birth weight is a major predictor of infant mortality (Healthy Start Association, n.d.). Low birth weight babies are more likely than normal weight babies to have health problems during the newborn period. Many of these babies require specialized care in the Neonatal Intensive Care Unit (NICU) (University of Virginia Health System, n.d.; Russell et al., 2007). Low birth weight babies may also suffer from Respiratory Distress Syndrome and require additional oxygen and mechanical ventilation to breathe until their lungs mature (March of Dimes, n.d.). A major proportion of pediatric hospital stays in the United States are for conditions in the neonatal period, which are among the most expensive diagnoses for all infants. A cross-sectional study using the 2001 Nationwide Inpatient Sample from the Healthcare Cost and Utilization Project found that preterm/low birth weight admissions totaled \$5.8 billion, representing 47% of the costs for all infant hospitalizations (Russell et al, 2007). Other problems common in low birth weight infants include neurological problems, weakened immune system, and difficulty regulating body temperature, eating and gaining weight. In addition, low birth weight infants are at risk for experiencing Sudden Infant Death Syndrome (March of Dimes, n.d.).

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	1.5	1.3	1.4	1.4	1.4
Numerator	175	149	164	164	164
Denominator	11452	11712	11590	11590	11590
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Reducing the rate of low birth weight and very low birth weight infants has been identified as a State Priority.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	8.0	3.6	6.5	6.5	6.5
Numerator	11	6	11	11	11
Denominator	137313	168487	168041	168041	168041
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

The Family Health and Systems Management section of DPH recognizes the impact and importance of injury prevention. To further this commitment, a Maternal and Child Health (MCH) staff member, LaWanda Walker, Management Analyst II, was designated to the Delaware Coalition for Injury Prevention and as a member of the Safe Kids Delaware Coalition. This enabled MCH the opportunity to focus on data driven priorities shared with sister agencies, develop community partnerships to address childhood injuries and help establish initiatives to protect the youth of Delaware.

The Delaware Division of Public Health (DPH) supports a widespread network of violence and injury prevention partners, largely through the Coalition for Injury Prevention (i.e. Delaware's Injury Community Planning Group (ICPG)), which is a coalition made up of more than 50 representatives of 35 agencies. Membership includes state and local government, not-for-profit and private entities. The Delaware Coalition for Injury Prevention, currently facilitated by the Office of Emergency Medical Services, a unit within the Division of Public Health, was an unfunded group until recently. In July 2011, Delaware was pleased to learn that our successful application was federally funded to develop a Violence and Injury Prevention Program (VIPP) under the Base Integration Component.

The new CDC VIPP grant funding will be used to build program infrastructure by securing a full-time injury prevention coordinator and a full-time epidemiologist. This new leadership will help update the state injury prevention plan, engage a statewide coalition to bring about systems-level changes, and strengthen the injury surveillance and reporting within the state.

- Injuries are a major global health problem, killing almost six million people each year and harming millions more. Until the late 1980s, injuries were viewed as unavoidable "accidents." Public health professionals now realize that there are clear patterns of how injuries happen; and they know that planned, targeted interventions can help prevent injuries from occurring. TEACH VIP E-Learning is a new online course on injury and violence prevention available to the public. It is based on TEACH-VIP, a comprehensive injury prevention and control curriculum developed by the World Health Organization and a global network of prevention experts. It was adapted for the web by EDC's Health and Human Development Division.

- Caught being Safe Program, Every child caught wearing a helmet received a coupon for "Rita's ice"

- Pool safety video , data is currently being collected

- DE CARES is a Delaware Health Sciences alliance (DHSA) program to examine sports related concussions in Delaware youth, which is in the forefront of in today's society, The DHSA is in partnership with Christiana Hospital for Children, A I DuPont , Jefferson University and the University of Delaware. The program is scheduled to begin in the fall of 2011.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	3.6	1.2	3.6	3.6	3.6
Numerator	5	2	6	6	6
Denominator	137313	168487	168041	168041	168041
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Through the Delaware Health Statistics Center, DPH collects a considerable amount of data on the burden of injuries. Data is collected on hospital discharges and mortality due to violence and injury, which allows our health officials and stakeholders to paint a picture of the incidence and prevalence of injuries statewide. As a result of the new grant award, the VIPP will be moved organizationally within the Family Health and Systems Management section of DPH, which also houses the Maternal Infant and Early Childhood Home Visiting Program and Maternal and Child Health/Title V Programs. Positioning the VIPP within the existing family health infrastructure ensures cohesion and is consistent with our strategic plans to emphasize linking and integrating public health programs in order to maximize protective factors and minimize risks across the lifespan.

Car Seat Safety Program - 293 car seat checked, Car seat fitting course

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	25.7	28.3	18.9	18.9	18.9
Numerator	21	33	22	22	22
Denominator	81711	116509	116614	116614	116614
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data

Notes - 2009

2008 Delaware Vital Statistics Data

Notes - 2008

2008 Delaware Vital Statistics Data

Narrative:

Delaware's Coalition is forging ahead with its committee members' intent on lowering the rate of childhood injuries. The Delaware MCH Bureau is involved in the Motor Vehicle workgroup as a part of its needs assessment to analyze severity of motor vehicle crash-related injury data for children and youth who are treated at a hospital. The coalition is divided into several risk areas that report information each quarter on actions, and upcoming plans. The risk areas are listed below with example 2010-2011 activities:

- Dog Bites -- hold Literacy Education Assistance Pups - "Love your Dog - Leash Your Dog."
- Drowning/Submersion -- Researching C-Spine surf injuries. Produced short pool safety video.
- Fires/Burns -- \$15,000.00 received by each county to purchase smoke alarms that will be distributed as a part of Fire Prevention Month. Children from the state of Delaware ages 6 - 18 that have sustained serious burn injury are invited to attend Delaware Burn Camp. The mission of the Delaware Burn Camp is to assist young burn victims from the State of Delaware in their adjustment to injury through the provision of a safe, supportive environment and providing companionship through physical and social activities in a camp setting.
- Motor Vehicles -- Offering car seat safety checks in all 3 counties; presentations on the Graduated Drivers License program; and offering "mock-tail" parties around the state throughout the holiday season.
- Poisonings
- Suicide/Suicide Attempts-- Depression screening offered throughout state. Delaware Suicide Gatekeeper Training "Project Life (Living is for everyone)" classes held in all 3 counties.
- Traumatic Brain Injuries/Spinal Cord Injuries -- 200 bike helmets and T-shirts were given out as part of a stay safe campaign. Every child caught wearing a helmet received a "Rita's Ice" during the "Caught You being Safe" program.
- Violent Injury: Assault, Firearm, Homicide -- 13 boys signed up for the Kindergarten through 10th grade Fire Arm Safety course. Approximately 20 students attended the anti-bullying safety-program in Sussex County where they have partnered with the First State Community Action committee, which plans to conduct more programs for that community. Additional neighborhoods were identified as areas where people are concerned with the same topics. Community safety surveys were completed to assist with identification of areas on concentration and subject matters such as gang-related drive-by shootings.
- Data Review Committee -- Reviewed data from Delaware Trauma System Registry for the years 1998-2009 and a summary was presented to the group. The information was able to show that resources for pediatric pedestrian trauma management and prevention should be directed in target zip codes of 19801, 19802, 19805, and 19720 where there were 319 pediatric pedestrian deaths.

Last year in Delaware four teens, ages 16-20, were killed in alcohol-related crashes and an astonishing 1,115 more were injured according to State Police statistics. Additionally at least 314 minors were arrested for DUI in 2009. To prevent this senseless loss of life, Delaware Governor Jack Markell is helping the State Office of Highway Safety (OHS) launch a statewide underage drinking prevention campaign: Under 21. Think. Don't Drink.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.0	3.6	387.4	387.4	387.4
Numerator	15	6	651	651	651
Denominator	166977	168487	168041	168041	168041
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Notes - 2009

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Notes - 2008

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Narrative:

This year, MCH collaborated with Safe Kids and the Office of Highway Safety to purchase car seats (35 infant and 50 combination seats) for a low-cost Child Safety Seat Program for the State of Delaware. The Bureau also assisted with the implementation of the Emergency Medical Services Curriculum for the Safe Transport of Pediatric Patients in Ambulances from the Riley Hospital for Children/Indiana University School of Medicine and the Safe Kids/ Emergency Medical Service for the Children Childhood Injury Prevention Conference. In addition, the Bureau helped cover the cost of a Rescu-Air Child transport seat with required cot harness and safeguard seat for use in child passenger safety training programs (i.e. a special seat used for training EMTs transporting young children and children with special needs).

The Low Cost Car Seat Program provides an opportunity for low income families, identified by hospitals and state social workers, to purchase a new car seat at an official Office of Highway Safety Fitting Station at minimal cost. The stations are staffed by trained Fitting Station Technicians according to the curriculum standards by the National Highway Traffic Safety Administration. The technicians have knowledge of the correct use and installation of child restraints and safety belts to help parents do a better job protecting their children and reducing the number one killer of our children today - motor vehicle crashes.

"Preventing Injury in the 21st Century", the theme for Delaware's 2011 Safe Kids/Emergency Medical Services for Children Childhood Injury Prevention Conference, was very successful whereby 150+ attendees shared knowledge, information, and resources addressing the following topics:

- Child Sexual Abuse Prevention Initiative: Stewards of Children
- Bites, Bumps, Bruises -- Preventing Common Injuries in Child Care
- Hanging out on line -- The Good, The Bad, and The Ugly
- Guns are not Child's play
- RX for Kids Safety

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	9.0	1.2	32.1	32.1	32.1
Numerator	15	2	54	54	54
Denominator	166977	168487	168041	168041	168041
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Notes - 2009

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Notes - 2008

2008 Delaware Vital Statistics Data.

NOTE: Historical Information from 2006-2007 is incorrect.

Narrative:

Risk factors for teen driver accidents include:

- Teens are more likely to speed and have shorter following distances.
- Teens have the lowest rate of seatbelt use compared with other age groups.
- Nationally, in 2005, half of teen deaths from motor vehicle crashes occurred between 3:00p.m. and midnight and 54% occurred on Friday, Saturday or Sunday.
- In a national survey from 2005, nearly 3 out of 10 teens reported that within the previous month they had ridden in a vehicle where the driver had been drinking.
- Having teen occupants increases the crash risk of unsupervised teen drivers.
- Crash risk is high the first year that teenagers are eligible to drive (CDC, 2008).

Risk factors for children include:

- Sitting in the front seat.
- Not being buckled up.
- Improper or non-use of safety seats.

Nationally, males ages 15-24 account for 30% of the total costs of motor vehicle injuries while making up only 14% of the population (CDC, 2008). In Delaware motor vehicle injuries totaled \$13,085,329 in hospital charges from 2002-2005 (Delaware Health and Social Services, 2008).

For serious injuries, there are long term consequences with ongoing costs for health care, rehabilitation services, loss of wages and lost education.

Research suggests that comprehensive graduated driver's license programs are associated with reductions of 38% in fatal crashes among 16 year old drivers. Graduated driver licensing programs are designed to allow teens to get their initial driving experiences under low risk conditions (CDC, 2008; Delaware Health and Social Services, 2008).

Young children should always ride in the back seat and buckled in. Infants should be in safety seats, properly buckled, and facing the rear of the vehicle. Parents and caregivers should learn proper safety seat placement and usage.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	200.7	176.0	159.5	159.5	159.5
Numerator	228	205	186	186	186
Denominator	113580	116509	116614	116614	116614
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010

2008 Delaware Vital Statistics Data.

Notes - 2009

2008 Delaware Vital Statistics Data.

Notes - 2008

2008 Delaware Vital Statistics Data.

Narrative:

- Promotion for Safety around Dogs. Graduated Driver License Course
- Fire Prevention Education , Al DuPont received a grant, which will go towards Fire Safety informational Handouts
- Since the beginning of the school year healthcare professionals, emergency professionals and Traumatic brain Injury survivors have presented 56 teen safety and program about teen choices.
- Boys in grades Kindergarten through 10th grade signed up for the after school Fire Arm Safety Course.

- On Thursday, October 29, 2009, Nemours/Alfred I. duPont Hospital for Children will announce a new partnership formed to decrease infant mortality in Delaware. The State of Delaware Child Death, Near Death and Stillbirth Commission and the Division of Public Health (Department of Health and Social Services) have joined forces with the duPont Hospital to help reduce the risk of infant injury and death due to unsafe sleep environments by providing education and resources to families. Through the Cribs for Kids(r) program, cribs will be distributed free of charge to families who cannot otherwise afford one. Delaware ranks 44th worst in the nation for infant mortality--approximately 8 out of 1,000 babies die every year. Reports show that most of these babies were not sleeping in an approved infant bed, a fact that contributed to the infants' deaths.

- Conference for daycare workers, nurses, social workers on the Growing epidemic of All Terrain Injury

- May is National Bike Safety Month. Safe Kids is urging parents, caregivers and children to use their helmets. Materials available on the Safe Kids website.

- May 1-7 is Safe Kids Week and coalitions are encouraged to hold community events focusing on issues that spike during the summer months such as sports safety, water safety and heat stroke. Materials available on the website.

- Safe Kids is continuing to focus on the issue of hyperthermia or heat stroke for children. Details on how to participate in this campaign are located on the Safe Kids website.

- Bike Safety: Dan Lacombe reported that he participated in several bike rodeos at schools throughout the state. The Bike Safety, Pedestrian Safety and Motor.

- Jen Whaley reported that the water safety committee will continue to do programs for water safety and will team up with the YMCA to promote water safety at the Sussex Safe Kids Day

- Farm Safety

- the Toy Safety Press Release was sent out today, toy injuries are up but the recalls are down. CPSC is emphasizing three tips for the holiday- Which Toy for Which Child, Gear Up for Safety and Be Aware

- a Carbon Monoxide contest for Middle School students

- Walk This Way/Halloween- Walk This Way Week held 6 programs where 950 children were reached. We partnered with Beebe Medical Center and Fed Ex who offered to work with us again next year.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	37.8	34.0	47.6	56.2	55.6
Numerator	1099	1000	1392	1648	1609
Denominator	29054	29397	29252	29299	28955
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

Number of reported cases of chlamydia in 2010. Projected number of 15-19 year women for 2010.

Notes - 2009

Number of reported cases of chlamydia in 2009. Projected number of 15-19 year women for 2009.

Notes - 2008

Number of reported cases of chlamydia in 2008. Projected number of 15-19 year women for 2008.

Narrative:

Compared to older adults, sexually active adolescents 15-19 years of age and young adults 20-24 years of age are at a higher risk for acquiring STDs for a combination of behavioral, biological, and cultural reasons. For some STDs, for example, Chlamydia, adolescent women may have a physiologically increased susceptibility to infection due to increased cervical ectopy. Cervical ectopy is how doctors describe the condition when columnar cells from the endocervix are present on the ectocervix, and thus more susceptible to infection. In particular, columnar cells are more likely to be infected by chlamydia, gonorrhea, and certain forms of HPV. Some degree of ectopy is normal during puberty, but the amount of ectopy usually decreases over time as a natural consequence of aging. The higher prevalence of STDs among adolescents also reflects multiple barriers to accessing quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. Recent estimates suggest while representing 25% of the ever sexually active population, 15-24 year-olds acquire nearly half of all new STDs (CDC, 2007).

The Centers for Disease Control and Prevention released a study in 2008 that estimated one in four (26 percent) young women between the ages of 14 and 19 in the United States -- or 3.2 million teenage girls -- is infected with at least one of the most common sexually transmitted diseases (HPV, chlamydia, herpes simplex virus, and trichomoniasis). The study also finds that African-American teenage girls were most severely affected. Nearly half of the young African-American women (48 percent) were infected with a STD, compared to 20 percent of young white women. The two most common STDs overall were human papillomavirus, or HPV (18 percent), and chlamydia (4 percent). Data were based on an analysis of the 2003-2004 National Health and Nutrition Examination Survey.

Chlamydia rates for persons 15-19 years of age continue to increase as they have for all age groups. Between 2006 and 2007, the increase for those 15-19 years of age was 7.7%. As in previous years, in 2007, 15-19 year old women had the highest rate (3,004.7 per 100,000 population) of Chlamydia infection compared to any other age/sex group. For the third consecutive year, gonorrhea rates for persons 15-19 years of age increased. Between 2006 and 2007, the increase for 15-19 years of age was 2.1%. In 2007 15-19 year old women had the highest rate (647.9 per 100,000 population) of gonorrhea infections compared with any other age/sex group.

Programs in Delaware include:

- The Division of Public Health provides testing, counseling and treatment for gonorrhea, syphilis, Chlamydia, and other conditions that can be sexually transmitted.

- The Sexually Transmitted Disease Program provides statewide management, education and training for the prevention and treatment of STDs.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	10.1	10.3	11.5	11.5	13.3
Numerator	1469	1499	1655	1655	1916
Denominator	145906	145178	144325	144325	144539
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

Number of reported cases of chlamydia in 2010. Projected number of 20-44 year women for 2010.

Notes - 2009

2009 data are not available.

Notes - 2008

HIV/STD/HCV Program

Narrative:

Sexually transmitted diseases (STDs) are infections that can be transferred from one person to another through any type of sexual contact. STDs are sometimes referred to as sexually transmitted infections (STIs) since they involve the transmission of a disease-causing organism from one person to another during sexual activity. It is important to realize that sexual contact includes more than just sexual intercourse (vaginal and anal). Sexual contact includes kissing and oral-genital contact. STDs probably have been around for thousands of years, but the most dangerous of these conditions, the acquired immunodeficiency syndrome (AIDS), has only been recognized since 1984.

Many STDs are treatable, but effective cures are lacking for others, such as human immunodeficiency virus (HIV), human papillomavirus (HPV), and hepatitis B and C. Even gonorrhea, once easily cured, has become resistant to many of the older traditional antibiotics. Many STDs can be present in, and spread by, people who do not have any symptoms of the condition and have not yet been diagnosed with a STD. Therefore, public awareness and education about these infections and the methods of preventing them is important.

Programs in Delaware include:

- The Division of Public Health provides testing, counseling and treatment for gonorrhea, syphilis, Chlamydia, and other conditions that can be sexually transmitted.
- The Sexually Transmitted Disease Program provides statewide management, education and training for the prevention and treatment of sexually transmitted diseases.
- School Based Wellness Centers provide a range of health services that include STD testing and counseling and are tailored to meet that needs of teens.

- Under Title X of the Public Health Services Act, the Division of Public Health offers a wide range of reproductive health services and supplies to both teens and adults. Services include but are not limited to physical exam including pap smear and clinical breast exam, birth control supplies, STD testing and HIV education, counseling and testing.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	11736	8200	3107	0	0	0	0	429
Children 1 through 4	46940	32798	12426	0	0	0	0	1716
Children 5 through 9	57637	40588	14756	0	0	0	0	2293
Children 10 through 14	58737	36554	14987	0	0	0	0	7196
Children 15 through 19	59518	40083	16336	0	0	0	0	3099
Children 20 through 24	58969	40471	15773	0	0	0	0	2725
Children 0 through 24	293537	198694	77385	0	0	0	0	17458

Notes - 2012

Narrative:

Demographic information regarding children 0-24 for 2009 is derived from Delaware Annual Population Projections.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	9770	1965	0
Children 1 through 4	39080	7860	0
Children 5 through 9	50044	7593	0
Children 10 through 14	49888	5106	3743
Children 15 through 19	54856	4662	0
Children 20 through 24	53980	4989	0
Children 0 through 24	257618	32175	3743

Notes - 2012

Narrative:

Demographic information regarding children 0-24 for 2009 is derived from Delaware Annual Population Projections. Hispanics, as a percent of the population, continue to increase at greater rates among the child-aged population in Delaware.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	22	8	14	0	0	0	0	0
Women 15 through 17	369	192	172	1	1	0	0	3
Women 18 through 19	860	509	340	1	7	1	0	2
Women 20 through 34	9108	6244	2393	16	428	3	0	24
Women 35 or older	1657	1219	332	2	102	1	0	1
Women of all ages	12016	8172	3251	20	538	5	0	30

Notes - 2012

Narrative:

Data are from the 2007 Delaware Vital Statistics records. Births in the state have remained consistent (at between 12,000 and 13,000 live births annually) since 2007.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	15	7	0
Women 15 through 17	278	91	0
Women 18 through 19	683	177	0
Women 20 through 34	7713	1395	0
Women 35 or older	1481	173	0
Women of all ages	10170	1843	0

Notes - 2012

Narrative:

Data are from the 2007 Delaware Vital Statistics records. It is generally thought that the Hispanic population, including the proportion of Hispanic live births, is increasing at a greater rate than the general population.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	101	49	52	0	0	0	0	0
Children 1 through 4	9	6	1	1	0	0	0	1
Children 5 through 9	7	4	2	0	1	0	0	0
Children 10 through 14	7	6	1	0	0	0	0	0
Children 15 through 19	32	16	16	0	0	0	0	0
Children 20 through 24	59	43	15	0	1	0	0	0
Children 0 through 24	215	124	87	1	2	0	0	1

Notes - 2012

Narrative:

Data are from the 2007 Delaware Vital Statistics records. In Delaware, due to small cell sizes, year to year fluctuations in death rates among specific child age groups in the State result in occasional instability for comparison purposes.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	86	15	0
Children 1 through 4	8	1	0
Children 5 through 9	7	0	0
Children 10 through 14	6	1	0
Children 15 through 19	28	4	0
Children 20 through 24	56	3	0
Children 0 through 24	191	24	0

Notes - 2012

Narrative:

Data are from the 2007 Delaware Vital Statistics records. In Delaware, due to small cell sizes, year to year fluctuations in death rates among specific child age groups in the State result in occasional instability for comparison purposes.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	230824	158193	61612	0	0	0	0	11019	2010
Percent in household headed by single parent	33.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2010
Percent in TANF (Grant) families	4.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2010
Number enrolled in Medicaid	111009	111009	0	0	0	0	0	0	2010
Number enrolled in SCHIP	6598	0	0	0	0	0	0	6598	2009
Number living in foster home care	1210	0	0	0	0	0	0	1210	2010
Number enrolled in food stamp program	57294	0	0	0	0	0	0	57294	2010
Number enrolled in WIC	12962	0	0	0	0	0	0	12962	2009
Rate (per 100,000) of juvenile crime arrests	2450.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2010
Percentage of high school drop- outs (grade 9 through 12)	3.9	3.2	4.9	0.0	0.0	0.0	0.0	0.0	2010

Notes - 2012

2011 Kids Count in Delaware Factbook

% of children in single parent households by race is not known.

In August 2010, there were 9,271 Children enrolled in TANF statewide.
Distribution by race is not known.

SCHIP Enrollment, December 2009. Statehealthfacts.org

2011 KIDS COUNT Delaware Fact Book, Households enrolled in Supplemental Nutrition Assistance.

2011 KIDS COUNT Delaware Fact Book

2011 KIDS COUNT Delaware Fact Book

2011 KIDS COUNT Delaware Fact Book

Narrative:

Table 9A presents miscellaneous demographic data. Race-specific estimates for a number of the items are not available or not captured.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	203638	27186	0	2010
Percent in household headed by single parent	0.0	0.0	33.0	2010
Percent in TANF (Grant) families	0.0	0.0	4.0	2010
Number enrolled in Medicaid	0	0	111009	2010
Number enrolled in SCHIP	0	0	6598	2009
Number living in foster home care	0	0	1210	2010
Number enrolled in food stamp program	0	0	57294	2010
Number enrolled in WIC	0	0	12962	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	2450.0	2009
Percentage of high school drop- outs (grade 9 through 12)	0.0	4.8	3.9	2010

Notes - 2012

2011 Kids Count in Delaware Factbook

% of children in single parent households by ethnicity is not known.

In August 2010, there were 9,271 Children enrolled in TANF statewide.
Distribution by ethnicity is not known.

SCHIP Enrollment, December 2009. Statehealthfacts.org

2011 KIDS COUNT Delaware Fact Book, Households enrolled in Supplemental Nutrition Assistance.

2011 KIDS COUNT Delaware Fact Book

2011 KIDS COUNT Delaware Fact Book

2011 KIDS COUNT Delaware Fact Book

Narrative:

Table 9B presents miscellaneous demographic data. Ethnicity-specific estimates for a number of the items are not available or not captured.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	185979
Living in rural areas	42824
Living in frontier areas	0
Total - all children 0 through 19	228803

Notes - 2012

Narrative:

Although large portions of Kent and Sussex County are rural areas, most of the state's children reside in urban areas along the Washington-Boston corridor.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	895173.0
Percent Below: 50% of poverty	7.0
100% of poverty	14.0
200% of poverty	30.0

Notes - 2012

2010 Delaware Population Projections

Narrative:

Health Status Indicator 11 presents the poverty-level distribution based on estimates from state population projections.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
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Children 0 through 19 years old	230824.0
Percent Below: 50% of poverty	7.0
100% of poverty	21.0
200% of poverty	30.0

Notes - 2012

Source: Statehealthfacts.org. Retrieved July 11, 2011

Narrative:

Health Status Indicator 12 presents the population distribution for children, 0-19 years, based on population projections.

F. Other Program Activities

The Office of Women's Health works to improve the health of all women in Delaware. Recent activities / accomplishments include:

SUSSEX HEART TRUTH CAMPAIGN -- The Delaware Office of Women's Health (OWH) successfully organized and presented the Sussex Heart Truth Campaign with its partners: La Red Health Center, the Delaware Division of Public Health's Diabetes Prevention and Control Program and DPH's Southern Health Services Section.

Between April 20 and June 8, 13 lectures highlighted by Powerpoint slides were held in Sussex County churches and community centers. Speaker presentations (in English and Spanish) covered the definition of heart disease, risk factors, methods to prevent heart disease, symptoms of stroke and myocardial infarction, and the frequent results of heart disease.

Most attendees were women aged 18-60 years. Participants represented the following ethnicities: 65% African American, 25% Hispanic, 7% Caucasian, 0.5% Asian American, and 1% 'Other' (does not sum to 100% due to rounding error). Of the 130 consenting individuals screened, 84% were overweight or obese; 64% were hypertensive or pre-hypertensive; and 57% were diabetics or pre-diabetics.

A few rare attendees with excessively high blood pressures or blood glucose levels were referred to private physicians and La Red Health Center. Although not required by the grant, public health nurses followed some participants to assist them in altering health behaviors.

DIMINUTION OF HEALTH DISPARITIES --The OWH extended its support of evidence-based programs and efforts to diminish health disparities through speaking engagements, such as at the Visions of Justice X conference in November. It also reviewed projects, such as the Kaiser Family Foundation's "Putting Women's Healthcare Disparities on the Map" for a local African American women's charitable group, Alpha Kappa Alpha.

DOMESTIC VIOLENCE PREVENTION -- The OWH became increasingly involved in preventing domestic violence:

- The Office supported the active Campaign/Walk of the Whitney's Lights Violence Against Women Group. Over 500 persons celebrated the life of Dr. Whitney Lucas and to affirm their commitment to end domestic violence.
- The OWH is a member and consultant to the Delaware Task Force on Teen Dating Violence.
- The OWH continues to participate in the Delta Project of the Delaware Coalition Against Domestic Violence, which formulated a state plan to prevent domestic violence.

The Office of Minority Health works to improve cultural competence and reduce disparities in

Delaware. Recent activities / accomplishments include:

HEALTH DISPARITIES -- OMH and the Metropolitan Wilmington Urban League produced Blueprint for Action. The report summarizes the recommendations generated from the Stronger Together II Minority Health Summit held on March 12, 2009. Another collaboration with the League created the Delaware Health Equity Consortium.

FUNDING -- OMH received the fourth of the five-year, federally funded State and Territorial Disparities Elimination Partnership Grant. Although funding was reduced, OMH was able to continue the contractual partnership with Delaware State University for the Health Professions Academy and provide resources to develop DPH's cultural competency training series. The grant also funds the interpreter training for 2009 and supports OMH's one FTE.

HEALTH PROFESSIONS ACADEMY -- Through this initiative, DPH seeks to increase students' likelihood of pursuing health careers by introducing fourth, fifth and sixth graders to health professions. Students also strengthen their math and science skills. Twenty-eight students enrolled and completed the 2009 class; 38 are enrolled in the 2009-2010 program. Partners are DPH's Rural Health Program, Delaware State University, and the Delaware Chapter of the National Medical Association.

CULTURAL COMPETENCY -- OMH partnered with the Office of Workforce Development to develop DPH: Journey to Cultural Competence," offered year-round. Thirteen DPH staff members were trained as facilitators. Secondly, OMH engaged Social Solutions, a training and consulting firm, to coordinate a series of workshops to build a culturally competent health care system in Delaware. Approximately 163 professionals attended the five trainings and gave overwhelmingly positive evaluations.

MEDICAL INTERPRETER TRAINING -- In April 2009, OMH coordinated and hosted its seventh "Bridging the Gap" Medical Interpreter Training. Of the 24 registrants, 21 (87.5%) successfully completed the training. Of the 93 certificate holders, 79 are registered members of Delaware's medical interpreter corps. OMH responded to several community requests to locate interpreters. In May 2009, interpreters staffed DPH's H1N1 Influenza Call Center. In the fall, about 20 interpreters worked at six mass vaccination clinics arranged in response to the epidemic.

OMH WEBSITE -- OMH's new website offers information on Delaware disparities, statistics, and upcoming trainings. Books, reports and links are included. Visit it at <http://www.dhss.delaware.gov/dhss/dph/mh/minority.html>.

The Special Needs Alert Program (SNAP) recognizes children with special medical needs child when the family calls 911. Since 2004, parents/guardians have enrolled over 181 children in SNAP statewide. Part of enrollment is completing a set of forms which includes a consent form giving permission to share medical information with local EMTs and paramedics so they can access it on the way to, or prior to an emergency call. Once paperwork is completed, the information is entered in a secure SNAP electronic data base located in the Office of EMS. The child's medical information is given to the 911 dispatch center, the county based paramedic service and the local fire company upon enrollment and is made accessible to responding units.

G. Technical Assistance

Technical Assistance Request

1. Develop Cultural and Linguistic Competence of Delaware Title V MCH personnel

According to the latest population estimates, in 2010 the State of Delaware had about 896,880

residents, of which 75% were Caucasian and 21% were African-American. The Hispanic population in Delaware has been increasing over the past decade. The latest estimates that are available regarding Hispanics are from 2007. In 2007, it was estimated that 6.5% of Delawareans were Hispanic. This is an increase of about 250% over the 2002 Hispanic population (estimated to be about 2.4% in 2002). According to the U.S. Census, in 2007, there were about 55,200 Hispanics in Delaware.

Delaware Maternal and Child Health is requesting assistance with building capacity of its MCH personnel through a workshop to (1) value diversity, (2) conduct an organizational self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities we serve.

2. Organizational development, conflict resolution and consensus building

As a part of the Family SHADE initiative, a comprehensive environmental scan was completed, followed up by a Collaborator's Summit in the Fall of 2010. Following these interactive table discussions, the group provided input regarding the major themes that emerged in the course of their discussions. Feedback included: comments about the need for a more collaborative culture in Delaware; the need to communicate better about programs and the possibility of devising a shared state-wide calendar; the importance of holding trainings together instead of fighting over families; the value of training on best practices concerning the use of social networking; the possibility of having a statewide online family advisory listserv (council) that could be surveyed periodically and provide feedback to the entire Family SHADE membership; funding barriers to collaboration; and, perhaps most importantly, the need to develop trust.

Partner organizations and families of CYSHCN provide input and strategic guidance to FSI's work via their participation on its Advisory Council. With support by Title V, the Center for Disabilities staff that are devoted to FSI, shepherded the launch of the umbrella activities very carefully to ensure that our collaborators felt a genuine sense of ownership and self-determination in governance, direction, and implementation. Despite palpable reluctance in the beginning, the partners are really excited, engaged and invested in making this structure work.

That being said, the structure--and the trust on which it is built--is still fragile and needs lots of care and cultivation in order to bloom into a strong organization. Technical assistance is requested to further refine and develop the Family SHADE organization, and assist the group with coming to consensus in order to achieve its goals and priorities.

3. Best practices - Public Input Strategies on the MCH Block Grant Application and Priorities Delaware Title V Maternal and Child Health Bureau is interested in technical assistance on exploring best practices for establishing regular and ongoing input and feedback from community partners, parents and the public on its programs. This includes strategies and opportunities for the public to provide ideas, comments, or concerns about MCH needs or programs, and to comment on the MCH block grant application.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (Line1, Form 2)	1966687	1966687	1966509		1966509	
2. Unobligated Balance (Line2, Form 2)	568010	568010	400000		400000	
3. State Funds (Line3, Form 2)	9922543	9922543	9589395		8625223	
4. Local MCH Funds (Line4, Form 2)	0	0	0		0	
5. Other Funds (Line5, Form 2)	0	0	0		0	
6. Program Income (Line6, Form 2)	784800	784800	784800		1024800	
7. Subtotal	13242040	13242040	12740704		12016532	
8. Other Federal Funds (Line10, Form 2)	1510076	1510076	1539610		1541209	
9. Total (Line11, Form 2)	14752116	14752116	14280314		13557741	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	4199811	4199811	3353814		3061344	
b. Infants < 1 year old	4984610	4984610	3348298		3058237	
c. Children 1 to 22 years old	1805491	1805491	2261837		2207929	
d. Children with	2086058	2086058	1543437		1506651	

Special Healthcare Needs						
e. Others	0	0	2137609		2086662	
f. Administration	166070	166070	95709		95709	
g. SUBTOTAL	13242040	13242040	12740704		12016532	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94466		100000		97260	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
ECCS	105000		132000		140000	
PRAMS	95000		85000		135000	
TITLE X	0		0		1168949	
Title X	0		1222610		0	
EHDI	125000		0		0	
Title X	1090610		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2010		FY 2011		FY 2012	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	3529324	3529324	4058584		3751597	
II. Enabling Services	3435200	3435200	5915444		5564199	
III. Population-Based Services	3372775	3372775	1172088		1144153	
IV. Infrastructure Building Services	2904741	2904741	1594588		1556583	
V. Federal-State Title V Block Grant Partnership Total	13242040	13242040	12740704		12016532	

A. Expenditures

FY 12 Maternal and Child Health Block Grant Application

BUDGET September 30, 2011 -- September 30, 2012

A. Expenditures

Title V Maternal and Child Health Block Grant Funding has historically funded staff positions within the Division of Public Health's clinic-based MCH programs, including the Smart Start/Healthy Families America home visiting program, Child Development Watch, and the Oral

Health program. As a result, most of the federal allocation of each year's MCH Block Grant award is budgeted for staff salaries, other employment costs (OEC), and indirect costs. Staffing vacancies and state hiring freezes over recent years has resulted in an on-going moving bubble of unexpended funds from current year funds. This year, for example, we anticipate "\$\$X" will remain as of 9/30/11 from the federal fiscal year 2011 award.

In addition to staff salaries and associated employment costs, the Title V funds supported a number of strategic initiatives over the past year:

1) Consultant -- Health Equity Associates \$49,000

During 2010 through 2011, the Delaware MCH program retained the services of a consultant to assist with the development of several initiatives related to injury prevention, the development of an early childhood provider survey, and a mixed methods approach to obtaining feedback from Home Visiting providers to assist with the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting community engagement process.

2) Family Support Initiative \$147,426

The Family Support Initiative, adopted a new name in 2011, entitled Family Support and Healthcare Alliance Delaware. Family SHADE supports several organizations and parent groups that focus on issues related to Children with Special Health Care Needs and their families. As described throughout this application, the contract is with the University of Delaware's Center for Disabilities Studies.

3) Smart Start "Best Start, Breast is Best" -- Breast Feeding Initiative \$30,000

MCH Funds were utilized to continue the Smart Start "Best Start, Breast is Best" project statewide within the Smart Start home visiting program. The program initiative supports women statewide to initiate and maintain breast feeding through the first six months of an infant's life. Breast pumps, educational materials and other supplies are made available to women who breast feed their infants. These services are women who are not WIC eligible or as an enhancement for services/supplies that WIC does not cover. A second part of this initiative is an annual conference, "Breast is Best". In 2011, the 3rd conference attracted 198 professionals (compared to 130 professionals in 2010) throughout the state.

4) Special Needs Alert Program (SNAP) \$20,000

The DE-MCHB continues to support the SNAP program, which recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in SNAP, EMS providers are alerted of the child's medical history. Providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, the emergency medical service team, together with the family will determine the child's most important needs.

B. Budget

B. Activities for FY12

Contractual \$273,426
 • Newborn Screening Program -- Long-Term Follow up

- o Develop a plan and budget for a newborn screening (Metabolic and hearing) long-term follow up program

Development and Planning Process

Consultation and facilitation services for the purposes of developing infrastructure for long-term follow up program for the newborn screening program (e.g. assess community perceptions; facilitate consensus building forums; Assess existing state wide capacity etc)
\$75/hr @ 200 professional hours

TOTAL \$ 15,000

• Folic Acid Education Initiative

o Develop a plan and budget for a folic acid education initiative (i.e. social marketing campaign targeted to population using varied media outlets)
DPH is proposing the development of a Folic Acid Education Campaign and airing of televised public service announcements to increase awareness and education of the nutritional and health benefits of folic acid across the lifespan, and it's role in preventing birth defects of the brain and spine. The campaign will target low-income women of childbearing age in Delaware. Other media activities include mailings to food stamp recipients, local cable shows and advertising. Professional educational materials on folic acid will be distributed to DPH health clinics, Family Planning providers, WIC and Federally Qualified Health Centers.

- 1,427 televised public service announcement spots (30 seconds) on Comcast Spotlight
\$19,998.00

- Educational materials \$5,000.00

- Other media activities (TBD)
\$15,000.00

TOTAL \$

39,998.00

• Smart Start "Best Start, Breast is Best"- Breast Feeding Initiative

a) Breast feeding educational supplies and materials

Purchase breastfeeding supplies and incentives to enhance the Breast is Best project at all Public Health field units statewide.

Product	Price	Quantity	Shipping	Total Cost
Breast Friend Pillows	25.00	100	100.00	2,600.00
Just Say No Cards		12.50	2	6.00 31.00
Nipple Shields	6.98	120	0	837.60
Milk Storage Bags		269.65	1	0 269.65
Hand Pumps	35.00	125	100.00	4475.00
Breast Pads	55.00	2	0	110.00

Newborn Care: A Guide to the First Six Weeks (English)

199.95 5 24.00 1023.75

Newborn Care: A Guide to the First Six Weeks (Spanish)

199.95 5 15.00 1014.75

Total Cost	10,361.75
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b) 4th Annual Breast is Best Conference

o Improve maternity care practices as a strategy to improve breastfeeding

o At the end of the 3rd annual conference, participants will be able to:

? Describe ways to improve common hospital practices that can interfere with breastfeeding.

? Describe adverse effects that common caretaking practices have on the newborn.

? Identify successful breastfeeding interventions with the late preterm newborn.

? Discuss breastfeeding advocacy projects and programs.

? Discuss the current breastfeeding recommendations from the A. A. P.

Conference Costs

Speaker fee	\$2,000.00
Meals and Incidentals	\$200.00
Airfare for speaker	\$800.00
Transportation	\$400.00
Hotel lodging for speaker	\$350.00
Subtotal	\$3,750.00
Venue Room	\$710.00
Food (\$30 per person)	\$6,000.00
Subtotal	\$6710.00
Copying/supplies/etc.	\$500.00
Contract Management	\$3,000.00
Sub Total	\$13,960

c) Recertification of International Board Certified Lactation Consultant (IBCLC) and Certification
Provide funding for recertification for the already certified International Board Certified Lactation Consultants (IBCLCs) and funding for training of 3 additional IBCLCs . Funding will be used to purchase current materials to provide best practice training to all field nurses in areas of post partum care, and breastfeeding statewide. An in-service training for health care providers will be delivered by a recognized Lactation Trainer in Summer 2012.

Recertification of IBCLCs	1 Public Health staff member	\$335.00
IBCLC Certification	3 Public Health staff members	\$6,000
Sub Total		\$6,335.00

TOTAL	\$28,428.00
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• Unintentional Injuries -- Childhood Injury Prevention Activities

The Delaware Division of Public Health (DPH) supports a widespread network of violence and injury prevention partners, largely through the Coalition for Injury Prevention (i.e. Delaware's Injury Community Planning Group (ICPG)), which is a coalition made up of more than 50 representatives of 35 agencies. Membership includes state and local government, not-for-profit and private entities. Although a majority of the coalitions work is related to adults, the infrastructure exists to add childhood injury as an essential component if additional resources are available. The Delaware Coalition for Injury Prevention, currently facilitated by the Office of Emergency Medical Services, a unit within the Division of Public Health, was an unfunded group until recently. In July 2011, Delaware was pleased to learn that our successful application was federally funded to develop a Violence and Injury Prevention Program (VIPP) under the Base

Integration Component.

The new CDC VIPP grant funding will be used to build program infrastructure and will help update the state injury prevention plan, engage a statewide coalition to bring about systems-level changes, and strengthen the injury surveillance and reporting within the state.

De BMCH, as a part of its needs assessment, analyzed severity of motor vehicle crash-related injury data for children and youth who were treated at a hospital. The two efforts to be undertaken this program year that will relate to the unintentional injury performance measure selected by De BMCH are:

In Sussex County, DeBMCH will, in partnership with OHS and others, conduct at least one child safety seat inspection/installation event in a community (not at an OHS-established station) setting, targeting Hispanic residents.

In Sussex County, DeBMCH will, in partnership with OHS and others, conduct at least one evening parent education session of teen drivers. OHS provides the speaker and De BMCH mobilizes partners and coordinates promotion of event.

De BMCH is building networks for future dissemination of prevention, risk-reduction and protective factor enhancement messages, resources and behavior change programs.

\$15,000.00

Family SHADE

\$150,000

The Family SHADE (aka Family Support Initiative) supports 40+ organizations, agencies, and parent groups throughout Delaware that focus on issues related to Children and Youth with Special Health Care Needs and their families. The MCHB will continue its relationship with the University of Delaware's Center for Disabilities Studies (CDS) who directs the umbrella organization for family support services for children and youth with special health care needs (CYSHCN). CDS will address performance through the following systems level and targeted organizational level actions:

- Increase efficiency of the systems servicing children, youth and young adults with special health care needs by reducing fragmentation and duplication and enhancing collaboration
- Care Coordination
- Capacity building of organizations, parents, youth and young adults through assessment and coordinated training. Assessment of organizations within the umbrella includes, at a minimum, the following: Governance, Sustainability, Strategic Planning and Evaluation.
- Develop an information and referral service process that integrates with the Delaware Help Me Grow system replication

Special Needs Alert Program (SNAP)

\$25,000

Since 2004 the Office of Emergency Medical Services (OEMS) has developed the Special Needs Alert Program (SNAP). The program recognizes children with special healthcare needs for Emergency Medical Services (EMS) providers. It is a pre-hospital notification program for any child who has special emergency care needs. When a child is registered in SNAP, EMS providers are alerted of the child's medical history. Providers will be able to give appropriate emergency care for the child and reduce the level of stress often experienced by the family when there is an emergency. In the event of a 911 call, the emergency medical service team, together with the family will determine the child's most important needs.

In partnership with the OEMS, the Maternal and Child Health Bureau supports the cost of a skilled individual in the coordination of the Delaware Special Needs Alert Program (SNAP) for 20 hours per week and a Special Needs Alert Program Assistant for 24 hours per week to maintain SNAP database and facilitate the SNAP enrollment process. The SNAP Coordinator will work

with the EMSC Program Manager and the Director of Children with Special Healthcare Needs. The SNAP Coordinator shall report to the Director of EMS to develop and implement a program to identify children with special healthcare needs for Emergency Medical Services personnel.

Supplies	\$2,500
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Other	\$551.85
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Audit Fee (.002 of budget)

The audit fee is .002 of the budget and covers DPH costs associated with auditing.

TOTAL BUDGET	\$276,477.85
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VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.